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The JOURNAL of the Kentucky State Medical Association

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IN EPILEPSY... PREREQUISITE FOR PARTICIPATION: THERAPY

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bibliography: (1) Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, p. 136. (2) Bray, P. F.: *Pediatrics* **23**:151, 1959. (3) Davidson, D. T., Jr., in Conn, H. F.: Current Therapy 1959, Philadelphia, W. B. Saunders Company, 1959, p. 512. (4) Smith, B., & Forster, F. M.: *Neurology* **4**:137, 1954. (5) Zimmerman, F. T.: *New York J. Med.* **55**:2338, 1955. (6) Lemere, F.: *Northwest Med.* **53**:482, 1954. (7) Perlstein, M. A.: *Pediat. Clin. North America*: **4**:1079 (Nov.) 1957. (8) Livingston, S., & Pauli, L.: *Pediatrics* **19**:614, 1957. (9) Carter, C. H., & Maley, M. C.: *Neurology* **7**:483, 1957. (10) Keith, H. M., & Rushton, J. G.: *Proc. Staff Meet. Mayo Clin.* **33**:105, 1958.

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MESSAGE FROM THE PRESIDENT

The Relative Value Concept

The American people not only live on consumer credit but they extend that credit to the absolute limit. Such precarious living demands a close budgeting of net income. A recent survey has shown that one quarter of our population has no dollar savings, one quarter between two and five hundred dollars, one quarter between five hundred and two thousand dollars, and the remaining quarter the great bulk of all dollar savings. In short, ninety million people possess no dollar cushion to absorb the crushing blow of an emergency.

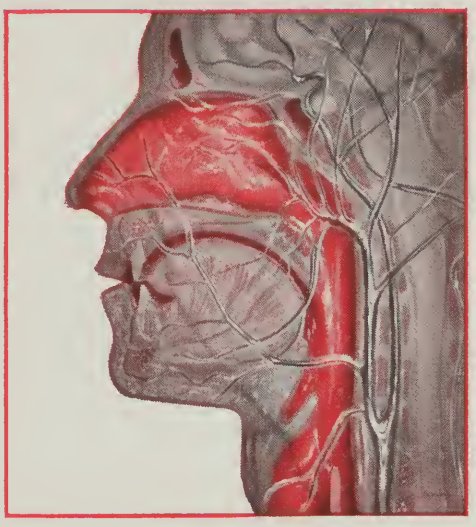
On the one hand, the American people are pleased with the service type of hospital insurance which almost absorbs the entire bill. And on the other, they are equally displeased with the indemnity type of insurance which pays only a part of their physician's bill. It is impossible to explain satisfactorily to a dissatisfied patient why the insurance carriers can not meet this latter situation. The desire for a fee for service type of professional insurance exists and is increasing.

The Relative Value Concept with its standard nomenclature and its conversion factor offers to the medical profession an opportunity to establish voluntarily and under its own control a standard schedule for professional services in a given area. If an entire state is included, the actuarial department of insurance companies can create a fee for service policy at a premium which people can afford and which they are willing to pay. The premium is the critical factor.

Every physician in this state is urged to study all the ramifications of the Relative Value Concept so that he can intelligently discuss its long range merits and demerits. The growing desire for a fee for professional service type of insurance will surely change during the immediate future—as it has already done in eleven states—into a demand for it. Time is available today for a comfortable, complete study of this unavoidable problem. This valuable time may no longer exist tomorrow.

Louis Abell Jr.

reaches all nasal and paranasal membranes *systemically*[1]



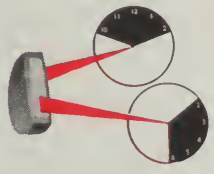
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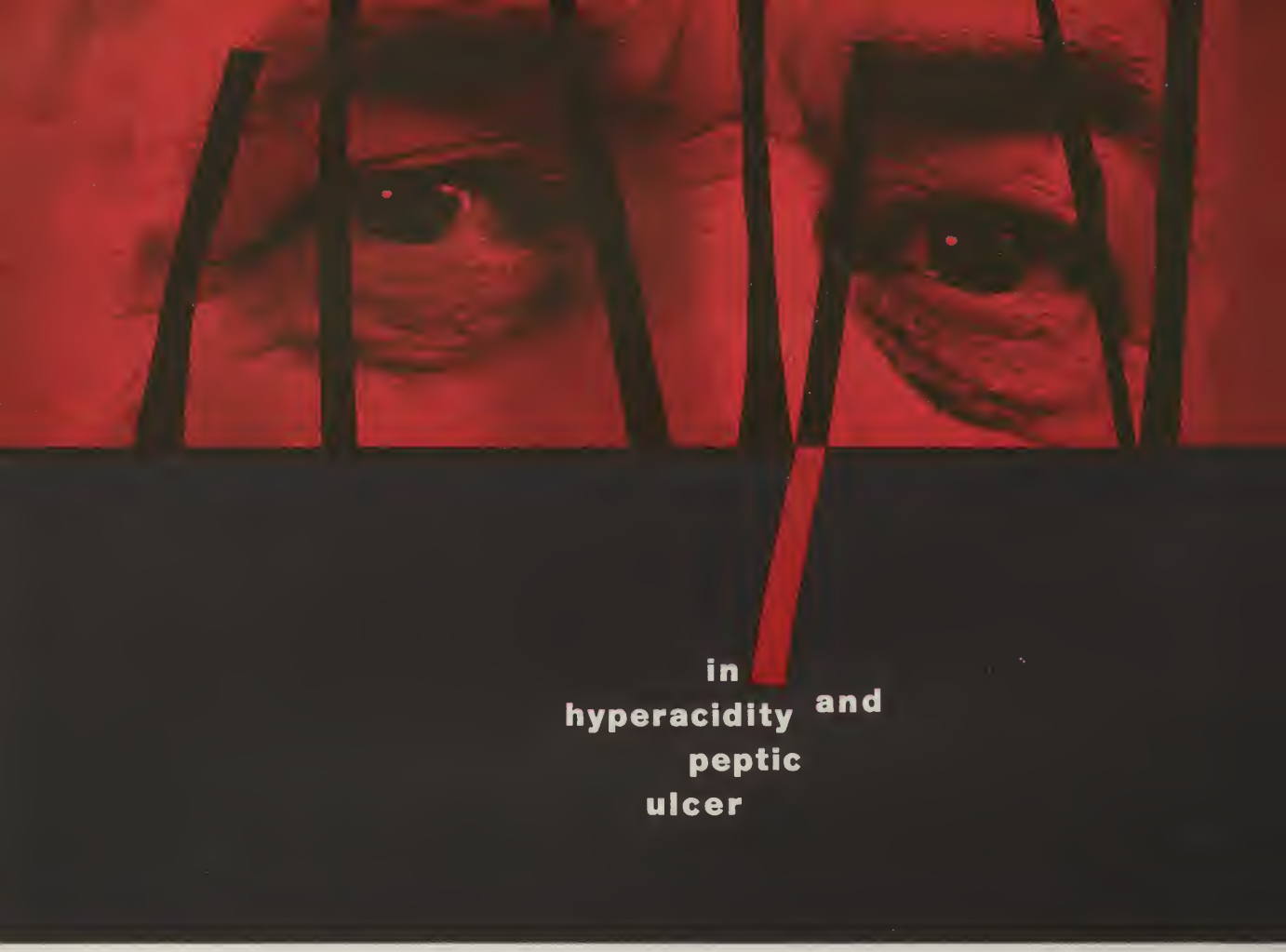
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2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
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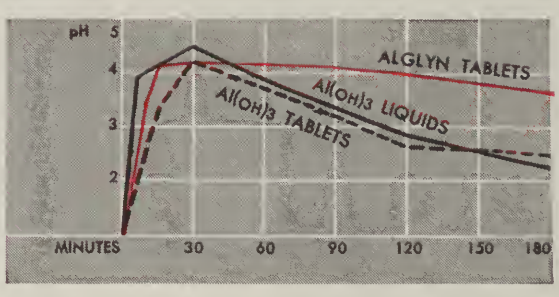
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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

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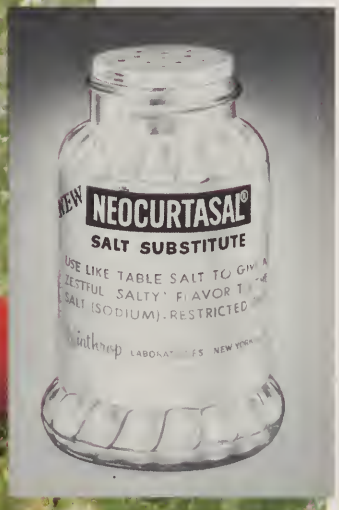
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Bagnall, A. W. (Univ. British Columbia, Vancouver, B.C.): A.M.A. Clinical Meeting (Scientific Section, Exhibit No. 124), Minneapolis, Minnesota, Dec. 2-5, 1958.

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Scherbel, A. L.; Harrison, J. W., and Atdjian, Martin: Cleveland Clin. Quart. *25:95, April, 1958.*

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Cramer, Quentin (Kansas City): Missouri Med. *55:1203, Nov., 1958.*

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*Thompson, R. E., and Hecht, R. A.: Am. J. Clin. Nutrition 7:311-317 (May-June) 1959.

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THE INSURANCE PAGE



Health Insurance After 65

A Progress Report

HEALTH insurance has just gone through a period of explosive growth. In the last decade it has become an accepted part of the family financial security for three out of four families in the United States.

It is estimated that as of June 1, 1959, some 124 million persons were protected against the cost of hospital care, a growth of 95 per cent in the last 10 years. More than 113 million had some form of surgical insurance, an increase of 75 million since 1949. Regular medical expense insurance (non-surgical) covered 77 million persons compared to 15 million in 1949. Major medical expense insurance—the fastest growing form of health insurance—covers 19 million persons today, a growth of over 1,000 per cent in the last five years.

The early traditional form of coverage—loss-of-income insurance, written only by insurance companies—covers more than 31 million persons. When the number of persons who have a formal sick-leave arrangement at their place of employment is added, the total figure comes to nearly 42 million, representing 65 per cent of the employed civilian population.

Real Challenge Faced

Even though substantial progress has been recorded by all types of health insurance programs, the health insurance business still faces a real challenge in broadening and filling some unmet needs.

Twenty years ago most health care protection was somewhat limited in scope, covering services connected with short hospital stays. In the years since, keeping pace with modern medicine, coverages and benefits have been continuously broadened and improved. The growth in quantity and quality of coverage was centered mostly among those in the active work market, either through group arrangements or individual purchases.

In the past five years the number of persons past 65 years of age has represented a growing, sizeable segment of the nation's population. Due to the lengthened life span, there is a greater need to provide satisfactory programs for medical service and financing to the senior citizens.

Today there are 15 million people who are 65 years and over, and this age group is increasing at the rate of about 300,000 a year. Their needs for medical care are as great or greater during retirement years and their financial resources are generally limited. Here, then, is one great challenge to the health insurance business.

Almost no health insurance coverage existed 20 years ago for Americans of advanced years. As late as 1952, only 26 per cent of this segment of the public 65 years and older were covered by health insurance. Today, reliable estimates show that at least 40 per cent of the elderly citizens group have some form of health-care protection and the number insured is rising more rapidly than the number of persons entering this age bracket.

Two-Way Approach

Actually the approach to insuring the retired people should be thought of in two parts. If the present-day progress of the business can be taken as a barometer, most people who today are in the active working force will be insured through some insurance arrangement at the time of retirement. The real problem is that group who are presently retired or past 65 years of age. The insurance business recognizes the need for still more intensified efforts to provide adequate and meaningful programs for the aged to help insure themselves against the costs of medical care.

Nine Methods

To meet this challenge a special meeting of the Health Insurance Association of America—representing some 265 insurance companies who provide 80 per cent of the health insurance written by the insurance business—last year unanimously endorsed a plan of action to accelerate the development of insurance programs for the present and future aged. The following nine methods are being used by member companies of the Association.

1. Older active workers normally will remain

(Continued on Page 90)



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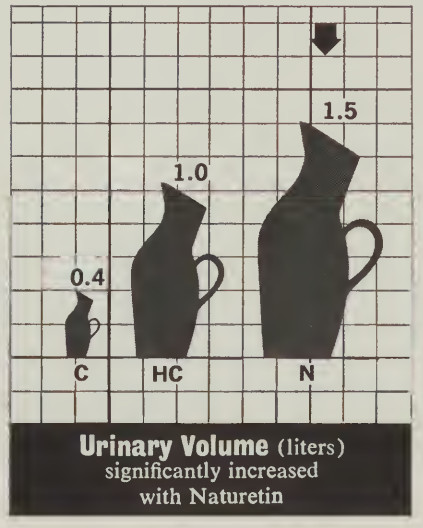
more closely approaches the ideal diuretic

Naturētin

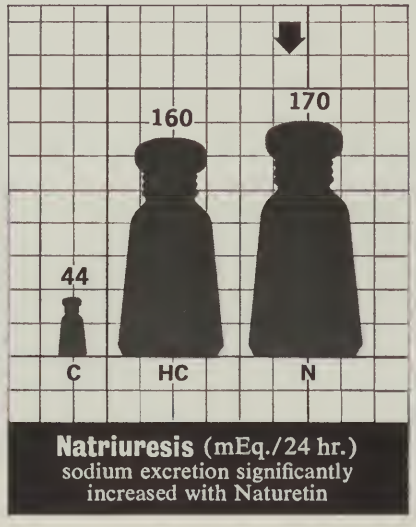
Squibb Benzydroflumethiazide

"When compared to other members of this heterocyclic grou
of compounds, this drug [NATURETIN] shows a significantly ir
creased natriuresis and decreased loss of potassium and bica
bonate. In this respect it more closely approaches a natural c
'ideal diuretic.' It is effective upon continuous administration an
causes no significant serum biochemical changes. It is effectiv
in a wide variety of edematous and hypertensive states an
represents a significant advance in diuretic therapy." *Ford, R.V
Pharmacological observations on a more potent benzothiadiazin
diuretic; accepted for publication by the American Heart Journa*

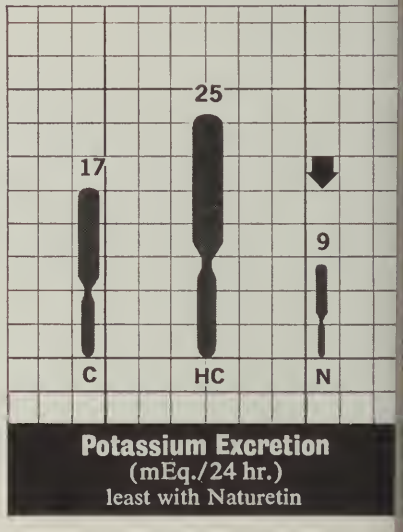
Comparison of electrolyte excretion pattern for the 24 hours following typical doses of chlorothiazide, hydrochlorothiazide, and Naturetin



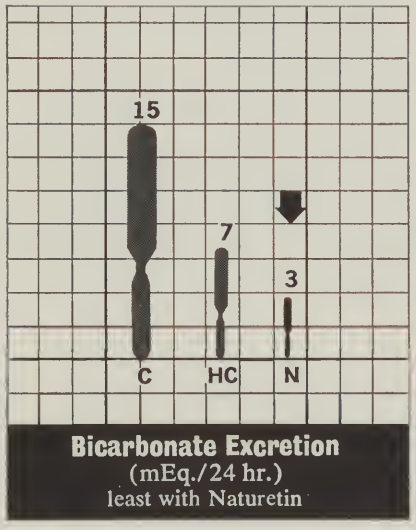
Urinary Volume (liters)
significantly increased
with Naturetin



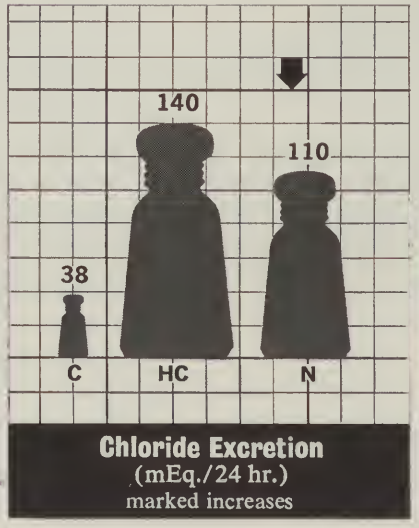
Natriuresis (mEq./24 hr.)
sodium excretion significantly
increased with Naturetin



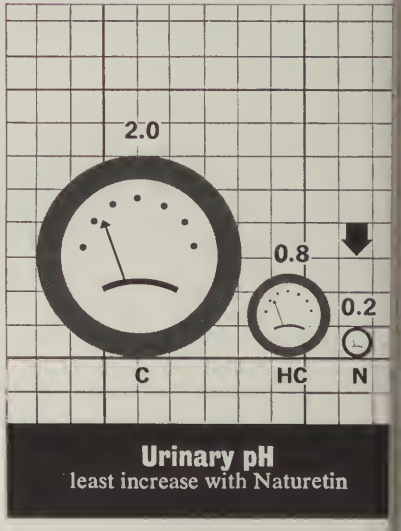
Potassium Excretion
(mEq./24 hr.)
least with Naturetin



Bicarbonate Excretion
(mEq./24 hr.)
least with Naturetin



Chloride Excretion
(mEq./24 hr.)
marked increases



Urinary pH
least increase with Naturetin

Typical Doses: Chlorothiazide—1,000 mg.; Hydrochlorothiazide—50 mg.; Naturetin (Benzydroflumethiazide)—5 mg.

1. Adapted from: Ford, R. V., Squibb Clin. Res. Notes 2:1 (Dec.) 195

A single 5 mg. tablet once a day provides all these advantages[2]

- prolonged action — in excess of 18 hours
- convenient once-a-day dosage
- low daily dosage — more economical for the patient
- no significant alteration in normal electrolyte excretion pattern
- repetitively effective as a diuretic and antihypertensive
- greater potency mg. for mg.—more than 100 times as potent as chlorothiazide
- potency maintained with continued administration
- low toxicity — few side effects — low salt diets not necessary
- comparative studies with chlorothiazide, hydrochlorothiazide, and Naturetin disclose that smallest doses of Naturetin produce greater weight loss per day
- in hypertension, Naturetin, alone or in combination with other anti-hypertensives, produces significant decreases in mean blood pressure and other favorable clinical effects
- purpura and agranulocytosis not observed
- allergic reactions rarely observed

[2]Reports (1959) to the Squibb Institute for Medical Research.

Naturētin —*Indications:* in control of edema when diuresis is required, in congestive heart failure, in the premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs (certain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb Rauwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

Contraindications: none, except in complete renal shutdown.

Precautions: when Naturetin is added to an antihypertensive regimen including hydralazine, veratrum, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all preparations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous drop in blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin regimen . . . in hypochloremic alkalosis with or without hypokalemia . . . in cirrhotic patients or those on digitalis therapy when reductions in serum potassium are noted . . . in diabetic patients or those predisposed to diabetes . . . when increased uric acid concentrations are noted . . . when signs—eg or abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

Naturētin —*Dosage: in edema,* average dose, 5 mg., once daily, preferably in the morning; to initiate therapy, up to 20 mg., once daily or in divided doses; for maintenance, 2.5 to 5.0 mg., daily in a single dose. *In hypertension:* suggested initial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending on the individual response of the patient. When Naturetin is added to an antihypertensive regimen with other agents, lower maintenance doses of each drug should be used.

Naturētin —*Supplied:* tablets of 2.5 mg. and 5 mg. (scored).

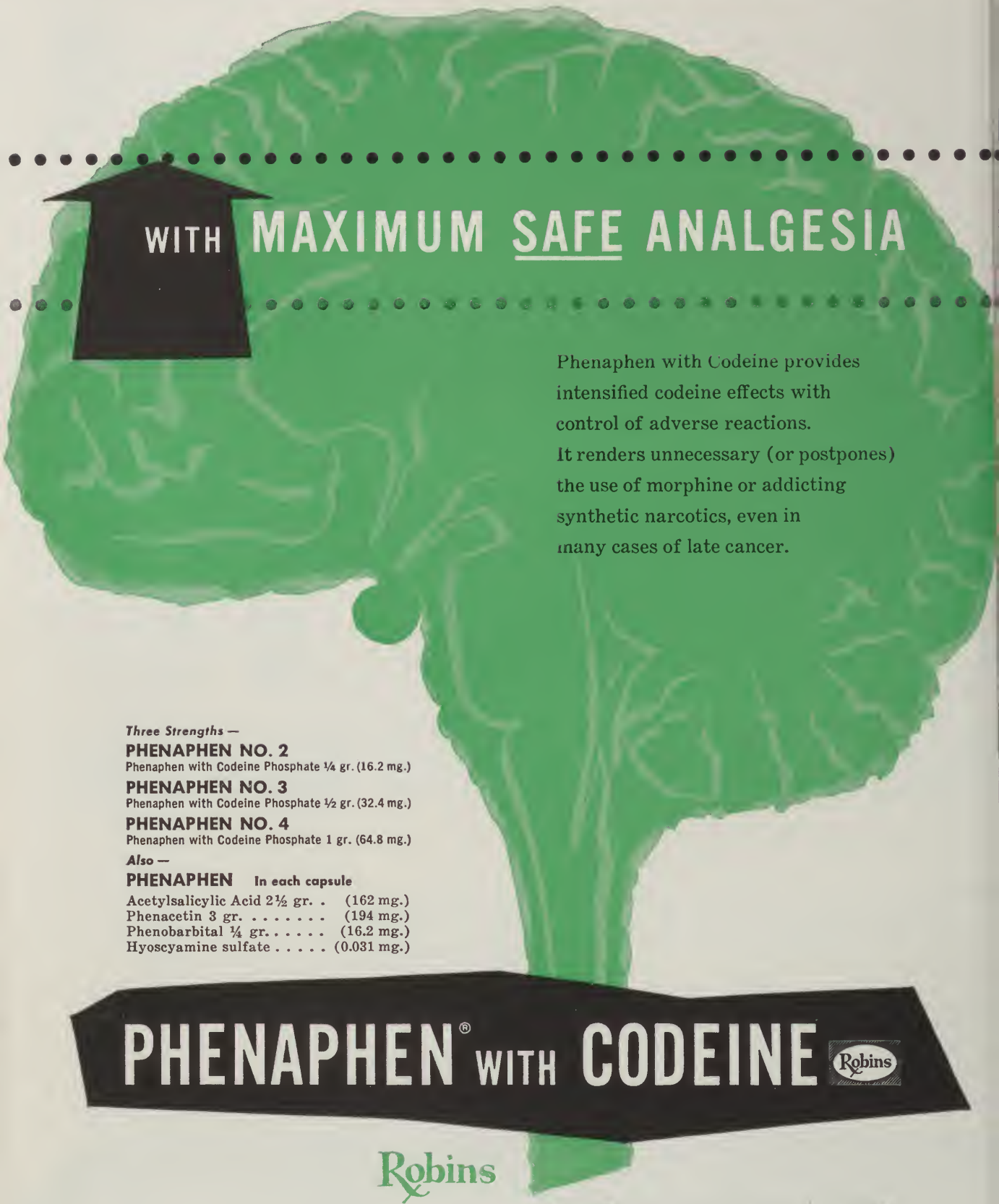
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Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

PHENAPHEN NO. 4
Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

Also —

PHENAPHEN **In each capsule**

Acetylsalicylic Acid 2½ gr. . (162 mg.)
Phenacetin 3 gr. . . . . (194 mg.)
Phenobarbital ¼ gr. . . . . (16.2 mg.)
Hyoscyamine sulfate . . . . . (0.031 mg.)

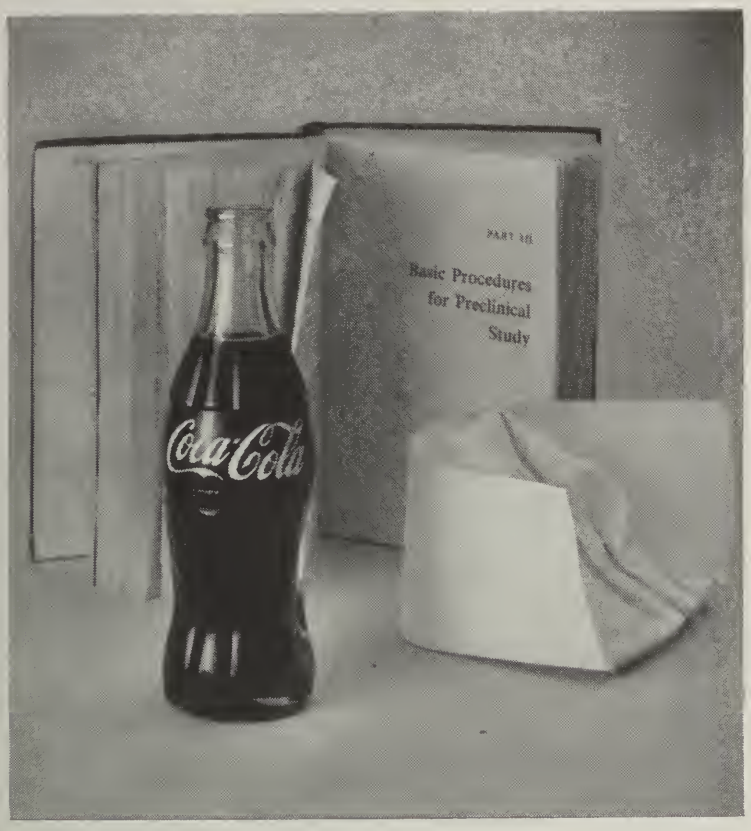
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a welcome
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with ice-cold Coca-Cola
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'Actidil'® brand Triprolidine Hydrochloride	2.5 mg.	1.25 mg.
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safe and effective for patients of all ages suffering from respiratory tract congestion

DOSAGE

	TABLETS	SYRUP (5 cc. tsp.)	
Adults and older children	1	2	three times daily
Children 4 months to 6 years of age	½	1	
Infants through 3 months	–	½	

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WASHINGTON NEWS DIGEST



Washington, D.C.—Congress embarked on a crucial election-year session with expansion of the Social Security program shaping up as one of the major issues.

It was virtually a foregone conclusion that some liberalization of the program would be voted in the Democratic-controlled Congress, but the key question was how far the changes would go. In every Presidential election year during recent years, the House and Senate have approved a broadening of the program.

Election Year Favorite

One of the prime reasons Social Security has been an election year "favorite" is that the program can be boosted without affecting the Federal budget. This is because it is financed through employer-employe contributions and is theoretically self-supporting.

Of special interest to physicians, of course, is the fate of the so-called Forand bill that would provide hospitalization, surgical services, and nursing home care for Social Security beneficiaries. This would be accomplished through even higher taxes on employes and employers than now scheduled through already-voted step increases.

Quick Enactment Sought

Supporters of the controversial legislation—vigorously opposed by the Administration, the American Medical Association, and allied organizations—launched their move to win enactment this session.

Sen. Pat. McNamara, (D., Mich.), whose Senate Subcommittee on Aging held a series of hearings across the country during the recess, announced at the conclusion of the hearings that they showed a need for expanding Social Security to include health care for the aged. He indicated he thought the Forand bill did not go far enough.

A battery of speakers at a meeting here of the American Public Welfare Association also urged a sharp increase in benefits, with some advocating "cradle to grave" security for all.

Not all of the proposals for extending the program involved health care.

Would Expand Disability Program

The Administration indicated it would recommend some expansion, especially in the disability program under which the Federal Government helps the states provide assistance to persons over age 50 judged to be totally and permanently disabled. An influential lawmaker, Rep. Burr Harrison (D., Va.), disclosed that he would introduce legislation to remove the age 50 limitation to allow all persons regardless of age to participate. He estimated this would not require any hiking of the taxes. Representative Harrison is Chairman of a House Ways and Means Subcommittee that held recess hearings on administration of the disability program.

Meanwhile, Chairman Wilbur Mills (D., Ark.) of the full Ways and Means Committee cleared the way for full-scale hearings this Congressional session on the entire issue of Social Security. In listing specific phases to be considered, however, the lawmaker did not mention the Forand proposal.

AMA's Stand on Broadcasting

A spokesman for the American Medical Association told the Federal Communications Commision that the AMA believes the best solution to objectionable advertising and programs on television and radio is for the industry "to clean its own house."

Dr. Eugene F. Hoffman, co-chairman of the AMA's Physician's Advisory Committee on Television, Radio and Motion Pictures, declared "the medical profession . . stands ready to assist the networks and individual stations in determining accuracy and good taste of broadcast material involving health or medicine—either commercial or public service."

"But, Doctor, I just can't swallow a lot of tablets"

"Little mother, just
ONE
BONADOXIN®
tablet stops morning sickness (you take it at bedtime)"



The formula tells why BONADOXIN quickly stops nausea and vomiting of pregnancy in 9 out of 10 cases.* Each tiny BONADOXIN tablet contains: Meclizine HCl (25 mg.) for antinauseant action / Pyridoxine HCl (50 mg.) for metabolic replacement

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BONADOXIN also effectively relieves nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis and motion sickness.

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For infant colic, try antispasmodic BONADOXIN Drops... stop colic in 7 out of 8 cases.*

Each cc. contains:
Meclizine 8.33 mg. / Pyridoxine 16.67 mg.

See PDR, p. 779.

*Bibliography available on request.

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for the tense and nervous patient

relief comes fast and comfortably

–does not produce autonomic side reactions
–does not impair mental efficiency, motor control, or normal behavior.

Usual Dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*–400 mg. *unmarked,* coated tablets.

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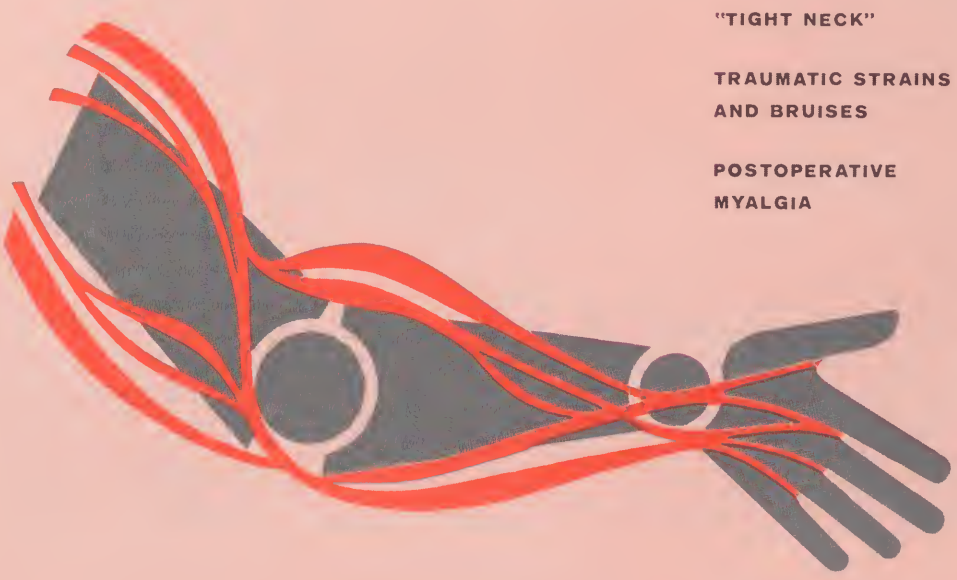
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. . . a new way to relieve pain and stiffness in muscles and joints

indicated in:

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■ Exhibits unusual analgesic properties, different from those of any other drug ■ Specific and superior in relief of SOMAtic pain ■ Modifies central perception of pain without abolishing natural defense reflexes ■ Relaxes abnormal tension of skeletal muscle

SOMA™

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SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

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EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

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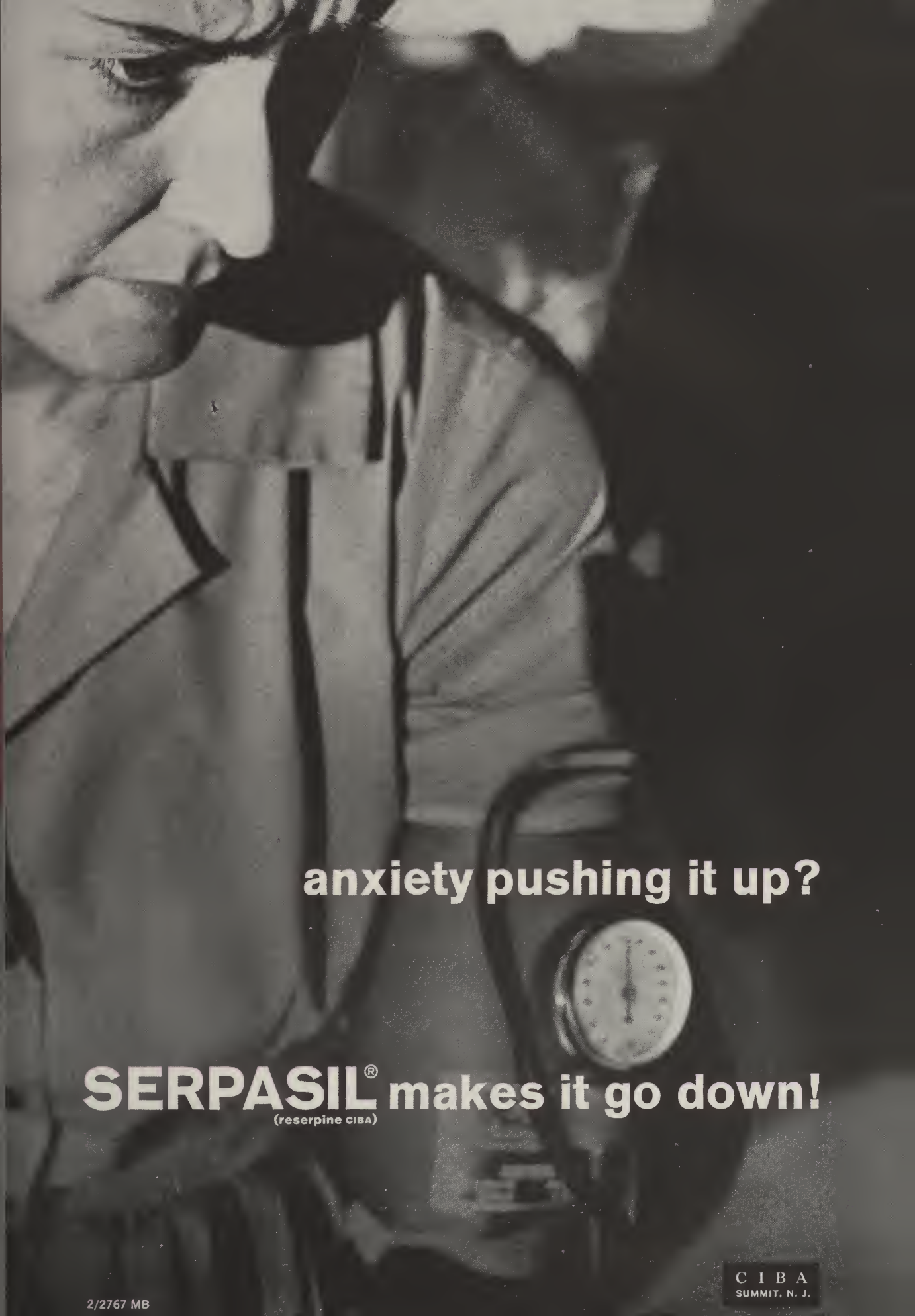
"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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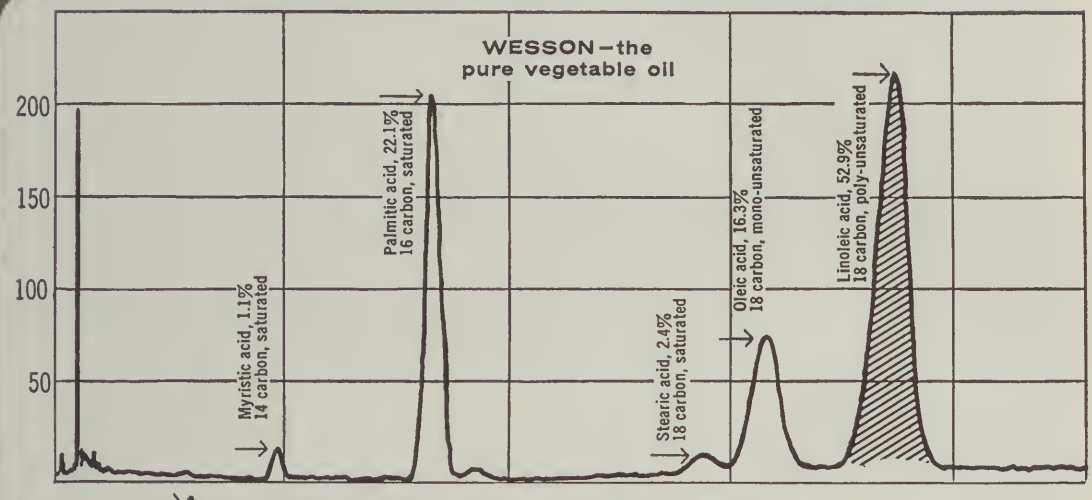
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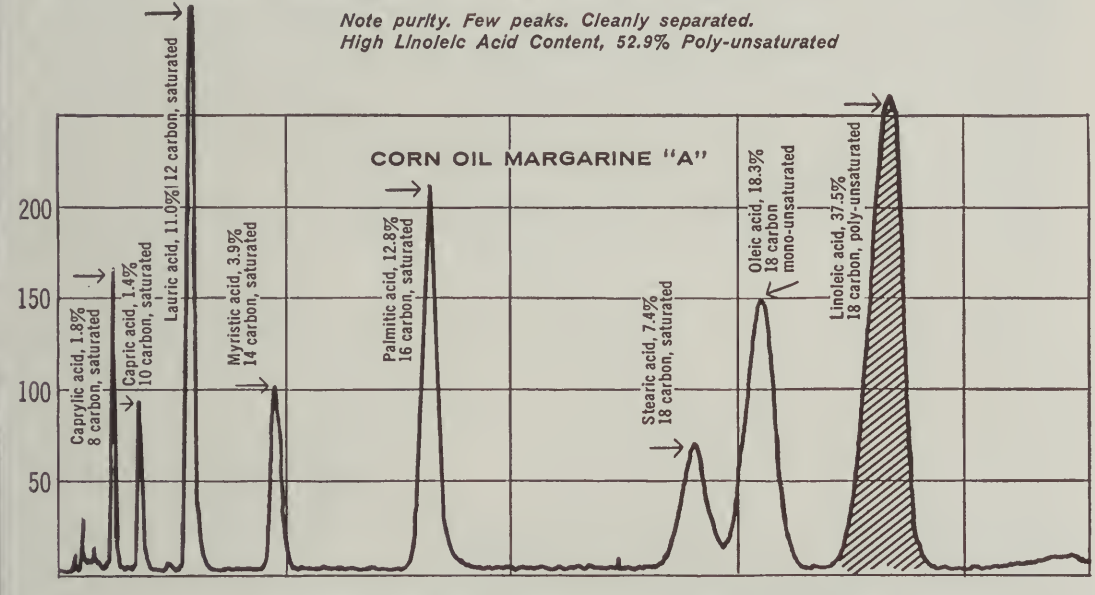
Linoleic acid glycerides	50% to 55%
Phytosterol (predominantly beta sitosterol)	0.4% to 0.7%
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Never hydrogenated—completely salt free

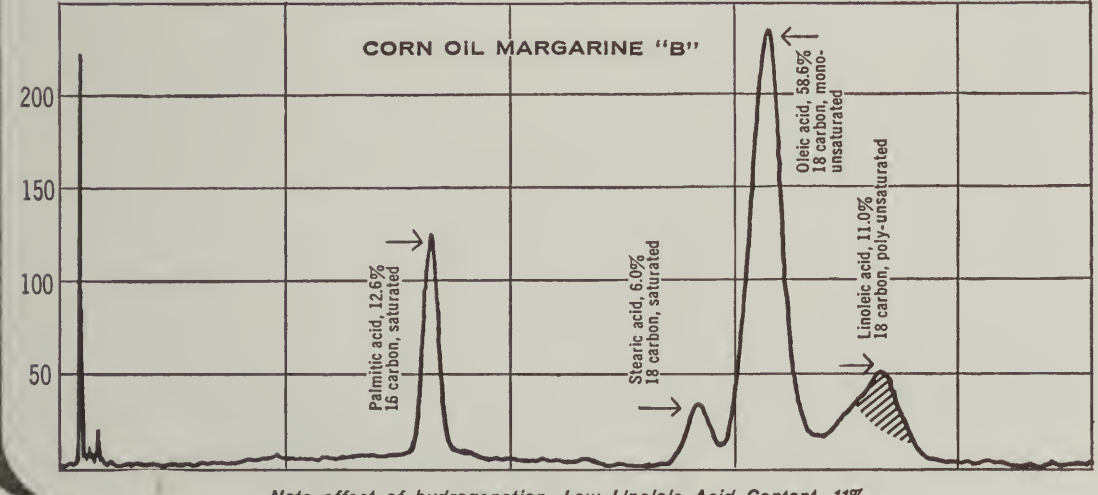
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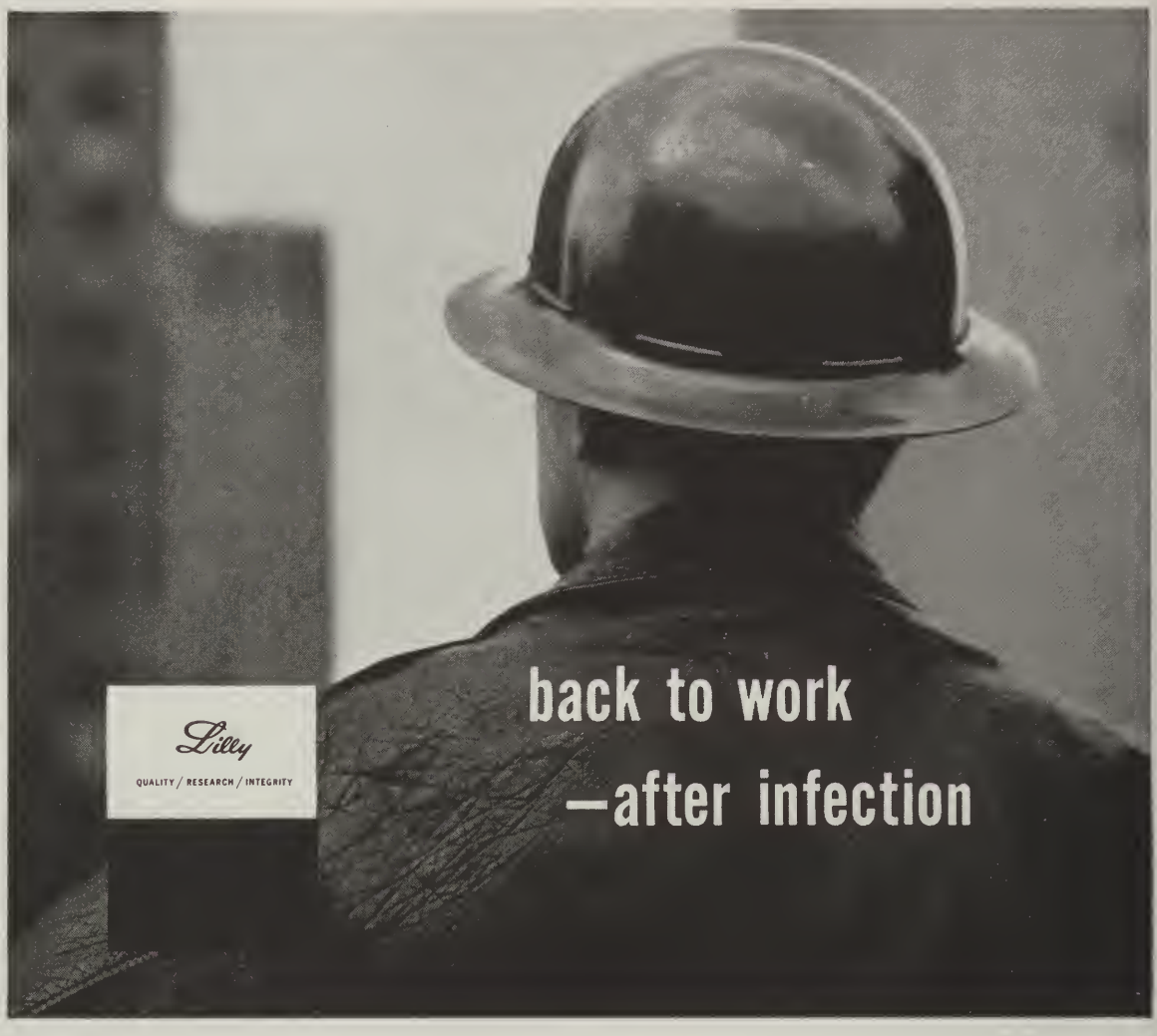
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The JOURNAL of the
Kentucky State Medical Association

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The Repair of Surface Defects of the Hand*

ANDREW M. MOORE, M.D.

Lexington, Ky.

THE successful repair of injuries of the hand demands a carefully planned approach which must take into consideration not only the part itself but the patient's requirements of the hand. Each individual has his own needs. These are emotional as well as functional; determined in part by age and occupation.

The hand is a composite of many functioning parts. It is not only a kinetic organ but sensory as well, depending upon bone, muscle, tendon, nerve and also upon the skin glove for its proper action. Limitation of motion and the disturbance of normal sensation by even a small scar can be disastrous.

First Considerations

Therefore the first consideration in evaluating such injuries and planning the restoration of the part is that which we see first, the skin. It is essential that repair of this be carried out as promptly and definitively as circumstances permit. Delay in the repair of the deeper structures may be tolerated and is often desirable, but repair of the surface is an immediate and critical problem. If prompt healing is assured, infection is prevented or minimized. This in turn permits early mobilization and return to normal activity or the rapid realization of the planned repair.

To achieve this recovery, several things must be done. First, using aseptic precautions, complete evaluation of the extent of injuries to the part must be made. In all but the most trivial cases, it is best to do this in an operating room where every facility is available. A careful history and sterile examination can quickly determine if this is necessary. All wounds and parts should be meticulously protected from further injury and contamination. A sterile supportive dressing should be gently applied until such time as definitive care can be accomplished.

Appropriate anesthesia should be employed and tourniquet hemostasis may be advantageous. The extremity should be scrupulously cleansed and shaved, protecting all open areas with sterile gauze. The wound itself should be copiously irrigated with sterile saline. Foreign bodies and devitalized tissue are removed. The wounds are irrigated again in the same fashion and the entire area redraped. Simple lacerations are closed with interrupted sutures of nonabsorbable material. Where flexion creases have been violated and blood supply permits, primary "Z"—plasty may be done. In severely traumatized hands with multiple injuries discretion is the better part of valor and for the moment function defers to prompt healing. Retrograde flaps, the result of injury, must be observed with great caution and there should

*Presented as a portion of a Symposium on "Surgery of the Hand" at the annual meeting of the Southeastern Society of Plastic and Reconstructive Surgeons, Charleston, South Carolina, March 21, 1959.

be no hesitation in removing nonviable skin. Frackelton has described a most useful test, which consists of releasing the tourniquet and observing the color changes in the doubtful skin. Blanching or cyanosis indicates poor circulation and in most instances it is better to sacrifice these areas than risk wound breakdown.

Avulsive Injuries

Small avulsive injuries such as the common finger tip amputation may be cared for in the emergency room. The application of thick split grafts or full thickness grafts from the antecubital fossa most often results in excellent repair when the original skin is not suitable or available for replacement. The use of composite touch pad grafts from the toes has much merit. This, however, is a complex procedure and requires hospitalization. In certain instances this repair may be highly desirable as better tactile function and appearance can be obtained.

More extensive skin losses must be repaired in the operating room. How this is accomplished is dictated chiefly by circumstances and the ingenuity of the surgeon. In general, simplicity is the keystone of success. Whether free or pedicle grafts are used depends upon the depth of the injury and extent of vascular damage. The most readily utilized method of replacement is of course the free graft. Whether full thickness or split thickness grafts are used is again determined by the situation. Circumstances must be ideal to utilize the former; whereas, the split graft can be used with greater likelihood of success in more precarious situations. It is often advantageous to think of it as a skin dressing to protect the wound until such time as definitive work may be carried out.

Pedicle flaps should be adequately constructed in such fashion as to provide comfort for the patient, for an uncomfortable position may be disastrous. The flap and its recipient site must be prepared in that manner which considers the functional lines of the hand. Violation of the mid-lateral line of the digits, the digital webs and flexion creases not only results in impairment of function but produces unsightly scars. Flaps should be tailored for the defect with adequate vascular pedicle and without the parasitic fat described by Bunnell. In addition, the wound must be entirely closed. This includes the pedicle as well as the donor and recipient areas.

The use of fileted digital skin is an excellent means of coverage and cross finger flaps are readily accomplished with very satisfactory results. The dorsal skin of the fingers may be borrowed without serious impairment to the donor site. It must be remembered that certain areas aside from the touch pads serve as the "eyes of the hand." The opposing and adducting surfaces of the thumb with the radial aspect of the index finger are such. Here it is often of benefit to shift local tissue into the defect if it can be done safely, and repair the donor area. To accomplish this the neurovascular bundle must be preserved.

Distant pedicles are most easily obtained from the abdomen. The donor site is either closed directly by undermining and approximation of the wound edges or grafted. The pedicle may likewise be closed with a graft or tubed. The latter is often advantageous for the greater mobility that it affords. If it is felt that the tube pedicle must be of considerable size, it is often safer to relegate it to a secondary procedure and devise some other method of immediate closure. Immobilization of the parts and post operative care must be punctilious.

Burns

Deep burns of the hand are a complex problem. Alone or in association with other trauma they constitute one of the most frequently seen severe injuries of this area. Fortunately, it is usually only the dorsum that is involved, although in small children grasping burns with deep destruction are common. Burns of full thickness involvement are best treated by excision of all questionable tissue and immediate replacement with thick split grafts. The results are most gratifying, return to normal activity occurring in a relatively short period of time.

When other areas of the body are involved in the burn, delay in coverage may be mandatory in consideration of the patient's general welfare. The preservation of life or protection of sight are the only matters which have precedence over the hands. When such delay occurs, the hands must be carefully protected

by bulky pressure dressings which avoid constriction and immobilize the hand in its functional position. Burns of the dorsum of the fingers, particularly those associated with rolling or crushing injuries, may produce extensive disability. The damage to the extensor slips, ligaments and often bone preclude in many instances a fully mobile hand. Again, prompt debridement and coverage offers the only hope and a pedicle flap may be the preferred manner of repair.

The chronic burn ulcer so often seen with dirty edematous granulations is prepared as promptly as possible for grafts. Exposed necrotic tendons are removed. Exposed bone is usually not disturbed, openings being left in the graft to allow for drainage or sequestration.

Chemical burns are much the same as thermal burns, however, the offending agent must be rapidly and completely removed. For example, phosphorous burns should be excised en bloc if possible to eliminate the chemical and prevent its further action.

Electrical burns with their usual deep damage are perplexing problems. Again, they must be approached with an aggressive attitude. Early debridement, possibly in stages, with rapid coverage is the order.

Summary

In summary, the repair of the injured hand requires a careful analysis and an aggressive surgical approach considering the patient's entire needs. The unreasonableness of extended disability and needless discomfort to obtain at best a questionable result is obvious. For the future function of the hand, it is imperative that infection be avoided; that prolonged immobilization and edema be minimized. To achieve this, primary skin healing must occur. The precautions to be taken and the means to this end have been briefly discussed.

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HEAR . . .

Congressman Dale Alford, M.D.

Little Rock, Ark., Ophthalmologist

at the 10th Annual

County Society Officers Conference

March 31, 1960

Gabe's Restaurant, Owensboro

A Study of the Somatic Chest Syndrome

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THE diagnosis of chest pain is frequently difficult because of the inadequacy of present diagnostic methods. There is, however, one category of chest pain—referred to in this study as the "somatic chest syndrome"—which is diagnosable with accuracy from the history and physical examination alone. This variety, elicited by palpation and percussion of the chest wall, has been attributed to compression of cervical and thoracic nerve roots,[1] irritation of the costochondral junctions,[2] and reflex sympathetic dystrophy following myocardial infarction.[3] The present report is an analytical study of this type of chest pain.

Materials and Methods

Five hundred male veterans consecutively examined for cardiovascular and pulmonary abnormalities between November, 1958, and April, 1959, at the Veterans Administration Regional Office, Louisville, Ky., were the material of this report.** In addition to a physical examination, each of these veterans ordinarily received a chest x-ray, electrocardiogram, serology and urinalysis. Such laboratory determinations as complete blood count, serum electrolytes, and non-protein nitrogen were available when necessary. The history of the chest pain was recorded in detail. As part of a thorough general examination of the cardiovascular and pulmonary systems, the tenderness of the chest wall and thoracic spine was evaluated by manual palpation and percussion.

Areas considerable distances away from the location of pain were tested first for establishment of a baseline of response. If withdrawal, grimacing, local muscle spasm, and other involuntary physical actions resulted, the tenderness was recorded as objective. If the only evidence for the presence of tenderness was the patient's verbal description, it was recorded as subjective. The nature of the tenderness was correlated with the veteran's description of his pain.

Results

Of the 500 men, 196, or 39 per cent, had tenderness of the chest wall, their average age being 55.1 ± 12† years. The average age of the men without tenderness was 52.7 ± 14 years. Tenderness was present in all parts of the chest (Table 1). The total of this table was greater than 100 per cent of men with tenderness, since, in some cases, there was almost equal tenderness in more than one area. In only one per cent was there any tenderness over the relatively stationary first ribs.

Tenderness occurred predominantly in the region of the second to sixth ribs. In two men, the tenderness was localized specifically in the left pectoralis muscle group.[4] Eighty-six per cent of the men with tenderness had the objective variety on light to moderate palpation, with no differentiation in terms of location. With heavier percussion, this became 95 per cent.

Without exception, every man with tenderness also had a history of pain. Palpation and percussion reproduced the described pain completely in 94 per cent and partially in six per cent of cases.

The pain was present from 1 month to 42 years, with an average of 6.5 ± 9 years. Only in 37.4 per cent had it worsened appreciably since its onset. No clear correlation existed

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†The second figure, in each case, represented the standard deviation.

between the nature of the pain and its location. The pain in a given individual followed a fairly constant pattern. In only 15.3 per cent of men with tenderness did the pain have different characteristics at different times, such as sharpness and aching, or tightness and soreness.

There was, however, great variation of pain from individual to individual. In 40.0 per cent, an ache was the predominant quality, in 13 per cent, soreness, and in 40.3 per cent, sharpness. Other described characteristics included tightness, pulling, pressure, tearing, "pins and needles," and stinging. In 29.4 per cent, an aching or soreness was described as being present much of the time. In the other individuals with this type of pain, an episode of discomfort lasted from several minutes to several days at a time, the average duration being 67 minutes. These episodes occurred as rarely as once a month or as often as five times a day, averaging once every seven days. The sharp pain was present for 22 minutes at a time and occurred every 6 days, on the average, with a wide range of variation.

Despite its variability, the pain had certain properties in common from individual to individual. It imperceptibly reached the level of conscious attention, its specific origin being recalled in only two cases involving blows to the chest. Only five per cent of men with tenderness had significant kyphosis or other postural abnormality. In 5.1 per cent of men with tenderness and 7.2 per cent of men without tenderness, a clear history of pleural trauma, such as a penetrating gunshot wound, infection, or surgical operation existed.

Although the pain was aggravated by respiration of various depth in 74.5 per cent of cases, chest movement was in no case a prerequisite to its existence. In only 6.6 per cent did it appear mainly after activity. In 6.1 per cent, it occurred mainly during the night. In 14.8 per cent, there was a slight to moderate amount of osteoarthritis in the joints of the body.

Essentially normal pulmonary and cardiovascular systems were present in 38.8 per cent of men with, and 37.8 per cent of men without, chest tenderness. Of the men with tenderness, 36 per cent had a cough productive of more than one-half cup a day of whitish sputum or any amount of greenish, yellowish, or blood-tinged sputum, while 43 per cent had no cough at all. For the other men, the figures were 17 and 60 per cent, respectively. The cough was associated with bronchial asthma in six per cent and with bronchiectasis in 7.6 per cent of men with tenderness. The corresponding figures for the remaining men were 7.2 and 6.9 per cent, respectively. Only in 8 per cent was the pain aggravated by specific episodes of coughing.

TABLE 1
Sites of Chest Tenderness

	Per Cent of Men with Tenderness
Sternum	7.2
Costosternal Junctions	
Right	3.6
Left	12.8
Junctions of the Ribs and Cartilages	
Right	15.8
Left	39.3
Whole Anterior Chest	
Right	28.6
Left	35.7
Lateral Chest	
Right	5
Left	17
Posterior Chest	
Right	12
Left posterior chest and thoracic spine	17
Whole Chest	9

Of the men with tenderness, 9.2 per cent had a history of myocardial infarction or angina pectoris, 3.6 per cent other forms of cardiac abnormality, such as aortic insufficiency, and 11.2 per cent elevated blood pressure. Eleven and one-half, 7.9, and 8.9 per cent of the remainder of the men fell into these respective categories. Four men had pain typical of both the somatic chest syndrome and angina pectoris at different times. Two men vaguely felt that their chest tenderness began during the period of treatment for myocardial infarction.

Discussion

Compensation neurosis can affect the history and physical findings in pension examinations. Undoubtedly, some of the men in the present study were guilty of exaggeration and, conceivably, even falsehood, despite the cautiousness and conservatism of the examiner. However, the applicant's ignorance concerning the clinical evaluation of his condition and his in-

ability to control his involuntary response to tenderness tended to minimize exaggeration. Furthermore, most of the men above the age of 65, at least, knew that, with varicose veins, hernias, and hemorrhoids, they had the ten per cent disability necessary for a retirement pension and that the presence of non-disabling heart or lung disease would lead to no additional income.

Every veteran who, by his undetected hypersensitivity, reduced the significance of this study as applied to the population at large, by so much increased its value when applied to difficult compensation cases with a question of intra-thoracic disease. Because of the large number of war, automobile, and employment injuries, compensation examinations recently became an extremely important medical activity, and any reduction in frustrating diagnostic inexactness would be a boon to harassed evaluation boards. The somatic chest syndrome reduced markedly the number of men with undiagnosed chest pain, whether realistic or exaggerated.

Highly Variable

The pain and tenderness in the present study were highly variable in location, frequency, duration, and intensity. The incidence of tenderness in the posterior chest and over the thoracic spine was relatively low. The fact that palpation and percussion in these regions reproduced the anterior and lateral chest pain in only eleven per cent of cases did not support the concept of root compression[1] as the chief cause of the pain. In many cases, the tenderness was localized at the junctions between the ribs and cartilages or at the costosternal joints. Previous studies revealed no consistent pathological abnormalities in these joint regions.[2, 3] Not one case of swelling of the costochondral joints[5] was present. Diffuse distribution of pain over the anterior and lateral chest suggested tendinous and muscular, rather than joint, involvement.

The long persistence and frequent recurrence of somatic chest pain arose from the configuration of the chest itself. Since the chest remained in constant respiratory movement, rest for irritated areas was inadequate. Coughing was only a mild contributing factor, since, as shown in the present study, only 58 per cent of men with severe cough had tenderness, while, on the other hand, many men without a significant cough also had tenderness. Lying on the chest was another source of repeated irritation, because of the diffusion of pressure over the rigid thoracic framework. Movement of the muscles of the shoulder girdle transmitted a pull to the chest and kept its irritated areas from adequate relaxation and rest. A reason for predominance of the left anterior chest as the site of pain could be repeated impact of the heart.

Other Characteristics

When tenderness of the chest wall was present, the diagnosis of the somatic chest syndrome appeared straightforward. Other characteristics of the pain were also of diagnostic value. The pain was usually aggravated by deep respiration. It had little specific relationship to activity or food intake, did not radiate into the neck or arms and recurred over long periods of time in the presence of good general health. The duration of the episodes was in many instances much longer or shorter than those of angina pectoris. The absence of hyperventilation, the wide variability in the location of the pain, and the older age of the men were incompatible with "functional cardiovascular disease."[6] Twelve per cent of the men without tenderness had pain which descriptively was indistinguishable from the somatic chest syndrome. They may have had tenderness at other times.

The somatic chest syndrome existed in men with abnormalities of the thoracic viscera, but had no specific relationship to visceral disease. It occurred less frequently in men with myocardial infarction and angina pectoris than in the total group. In addition, its incidence was relatively low in men with a history of pleural trauma and pleuritis.

Men who imagined a cardiac etiology for their pain were most discomfited by it. The relief which they experienced on learning its noncardiac nature was striking. Most of the men accepted intermittent discomfort philosophically and did not seek medical care for it. The continuous variety of aching or soreness was

usually of low-grade intensity, and only intermittently the object of distinct conscious attention.

The importance of the somatic chest syndrome lay chiefly in the diagnostic security which it provided. It removed a large amount of chest pain from the categories of psychosomatic and visceral disease. It carried with it a positive reassurance that normal patterns of living could be resumed without fear and that usefulness in society was not over. It was, for many, a diagnosis of renewed hope.

Summary

Thirty-nine per cent of 500 routinely examined adult men had tenderness on palpation and percussion of the chest wall. Every man with tenderness had a history of similar chest pain. The nature, distribution, duration, and frequency of the pain were highly variable, and no single etiological explanation was satisfactory in a majority of cases. The pain was ordinarily aggravated by deep inspiration and was independent of food intake or activity. A reason for its persistent recurrence was the constant motion of the chest with respiration and general body movements. It had no relationship to cardiac or pulmonary abnormalities. Only men who feared a cardiac etiology for the pain were greatly discomfited by it.

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Ecthyma Contagiosum ("Orf")

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Ecthyma contagiosum, or orf, is a contagious viral disease in sheep that may be transmitted to man. It was introduced in medical literature by Peterkin[1] in 1937, but to my knowledge this is the first time it has been reported in Kentucky.

In sheep the disorder begins as a vesicopustular eruption of the mouth and genital regions. The lesions form a dry crust and heal in three to four weeks. The sheep may lose weight; however, usually there are no systemic effects. The virus has been found in dried crusts[2] and seropurulent material. It is resistant to drying and freezing and remains viable for long periods. The saliva and blood serum do not contain the virus; the serum of an animal that has recovered contains no known protective antibodies, but an attack confers permanent immunity. Vaccination of sheep with virus which has been attenuated by drying and placing in glycerine and physiologic solution of sodium chloride gives rise to a mild reaction which confers permanent immunity.

The infection occurs shortly after the lambs are put on pasture in the spring. A few lambs will become infected from dried crusts on the pasture in which the virus from the previous season is still viable, and within weeks it will become epidemic and affect most of the lambs. The virus spreads by contact with contaminated water or forage and direct contagion. Ulcerative lesions may occur on the mouth, tongue, and pharynx. However, it is probable that the ulcerative lesions occur secondary to infection by bacteria screw worms or blow fly. Death may occur from this complication. Men have developed the disease while helping prepare the vaccine and while vaccinating sheep. Goats also develop the disease; however, mice, and guinea pigs are naturally immune.

Persons who are infected with orf have a history of exposure to sheep that have infections of the skin. However, usually the in person has not been exposed to sheep viously and has been working with them only two to three weeks. The lesions start as papules and vesicles and may go on to form what appears to be granuloma pyogenicum. The regional lymph nodes may be enlarged, and the lesions may be umbilicated.[3] The lesions usually clear spontaneously in three to four weeks with or without treatment. Immunity in man is lasting following an attack. In areas where the disease is common, sheep herders may not seek medical aid. Some people refuse to take care of sheep that are infected.[5]

Pathology

The microscopic appearance of the lesions in man and in sheep is similar except that the infiltrate is more acute in lambs, and more polymorphonuclear neutrophils and eosinophils are seen in lambs. Balloon degeneration, multiloculated vesicles, pustules, granulomatosis, and papillomatosis are characteristic features in man and in sheep.

It may be difficult to differentiate between milker's nodules and orf, but the following points may be of help in separating these two diseases. In orf there is a history of exposure to sheep that have infections of the skin of the mouth and nonhairy areas. In milker's nodules there is exposure to cows with warts on the teats. There may be lymphadenopathy in milker's nodules; there is rarely adenopathy in orf. The pathology of the two diseases is similar; however, the infiltrate is more acute in milker's nodules. Immunity studies are specific for each disease. Typical lesions are found on the chorioallantois from tissue in orf, but in milker's nodules there is either no growth on the chorio-

allantois or the growth dies rapidly on passage. Wheeler and Cawley[7] have pointed out that ecthyma contagiosum and sheep pox are separate diseases. Sheep pox is a systemic viral ection, and the cutaneous involvement is part of the generalized disease.

First Case

A 31-year-old white male farmer had a vth on his left temple for two weeks. It started as a small red spot and had berapidly larger. He had scratched the area a nail about one week before the lesion ted growing. Of 200 lambs on the farm here were about 15 that had had eruptions around their mouths. None of the old sheep were affected, but two lambs that had the infection died. The infection as a rule lasted four or five weeks and then cleared. The patient handled many of the lambs daily. He also had two cows. The cow that he milked had no trouble; however, the cow that was nursing calf had small warts on her teats.

There was an elevated tumor on his right temple (Fig. 1) which measured 2.0 cm. in diameter. The surface was red, and there was

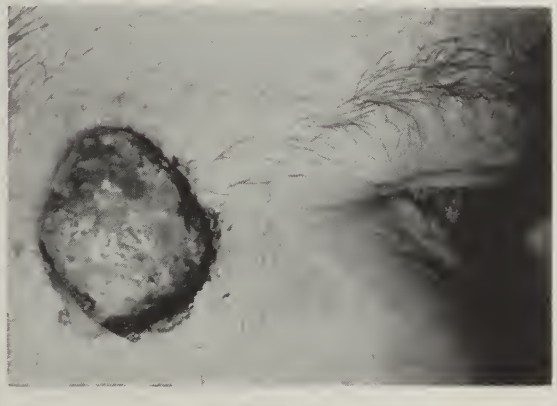


Figure 1

Lesion on the right temple of patient in Case 1 measured 2.0 cm. in diameter.

a gray exudate covering part of the lesion. The lesion was excised and hematoxylin and eosin stain showed fingerlike downward projections of the epidermis, edema, and intraepidermal vesicles. Balloon degeneration of the epidermal cells was present. A thick, fibrino purulent exudate was on the surface of the skin. There was dense infiltrate underlying the

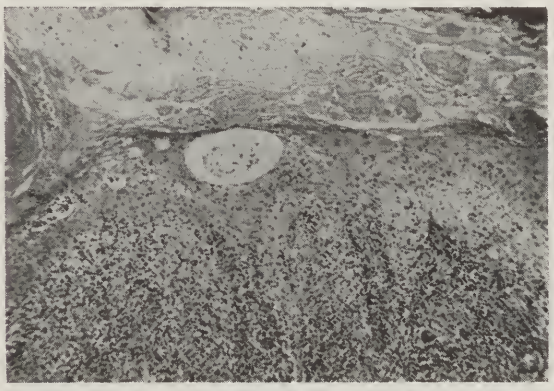


Figure 2

Photomicrograph of lesion from patient in Case 1 shows balloon degeneration of the epidermal cells, a thick fibrinopurulent exudate, fingerlike downward projection of the epidermis, and an infiltrate in the dermis consisting of histiocytes, lymphocytes, plasma cells, and occasional eosinophils and neutrophils.

epidermis which consisted of histiocytes, lymphocytes, plasma cells, and occasional eosinophils and neutrophils. (Fig. 2)

Course: The lesion was excised and the base cauterized. The area healed uneventfully with little scarring in about two weeks.

Second Case

A 41-year-old white female had had a sore on her finger for five days that had been getting larger. It started as a red circle with a blister in the center. She reported she had been feeding a lamb milk three times daily for three or four months. The lamb's mouth had been broken out for one month. Four other lambs on the farm had had a breaking out around their mouths.

The elevated red vesicular lesion on her finger measured 0.8 cm. in diameter. It was on the dorsal aspect of the right index finger.

Course: The lesion was excised for microscopic examination and the base cauterized. The area healed uneventfully in two weeks.

Microscopic examination of the lesion showed serum covering the epidermis. The epidermis showed vacuolization of many of the cells. There was fingerlike downward projection of the epidermis. A dense infiltrate was present in the dermis which consisted of histiocytes; plasma cells, lymphocytes, macrophages, and occasional polymorphonuclear leukocytes.

A three-month-old lamb from the farm of the patient written up as Case I had had a breaking out around his mouth for three weeks. (Fig. 3) The crust had come off a few hours previous to microscopic examination of the lesion. Examination showed edema of the epidermis with multiloculated vesicles. There was a dense infiltrate in the dermis, which consisted of histiocytes, macrophages,, and many polymorphonuclear leukocytes.

Discussion

Cases 1 and 2 involved people in different counties in Kentucky. Their farms were approximately forty miles apart. In both cases there was history of exposure to lambs that had eruptions around their mouths. The wife and three children of the patient in Case 1 had no breaking out. The husband and two children in Case 2 had no skin trouble. It might be concluded that the disease is not very contagious from one human to another, particularly as one of the patients was a female with usual household duties of bathing the children.

The only significant pathological difference between the human and animal infection is the more acute inflammatory infiltrate in the latter. The epidermal changes are similar. In Case 1 there was a question of milker's nodules; however, the patient had not been in contact with the cow with lesions on the teats.

Summary

Two human cases and one animal case of orf are presented with clinical and pathological findings. Differentiation between orf and milker's nodules is discussed. Orf is apparently not very contagious, if it is contagious at all, from one human to another human. It is very contagious among lambs.



Figure 3
Eruption on lip of lamb.

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Gastrojejunocolic Fistula

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A GASTROJEJUNOCOLIC fistula represents a failure in the treatment of peptic ulcer. Johnston states[1] "Gastrojejunocolic fistula, in the majority of cases, is a complication of inadequate surgery for peptic ulceration," and Berman has called it "a man-made disease."[2] While gastrojejunocolic fistulas have been known to occur after virtually every type of peptic ulcer surgery, it is true that most of them have followed gastroenterostomy, an operation generally considered inadequate in the treatment of peptic ulcer. The number of fistulas decreased with the wide adoption of subtotal gastrectomy. However, the marginal ulcer is the forerunner of the fistula, and as long as there are marginal ulcers, there undoubtedly will be a few fistulas.

Prior to the advent of surgery for peptic ulcer, nearly all enterocolic fistulas were secondary to cancer. Czerny reported the first gastrojejunocolic fistula following gastroenterostomy in 1893, twelve years after Wolfler performed the first gastroenterostomy in 1881. Since then, the proportion of fistulas due to peptic ulcer surgery has increased steadily until it far exceeds that due to cancer. This paper will discuss those fistulas due to peptic ulcer surgery. One case, which presents many of the typical features of this disease, is reported.

Incidence

Priestley and Gibson,[3] Wangensteen,[4] and Lahey[5] found the average incidence of jejunal ulcer after gastroenterostomy to be approximately 15%. Marshall and Knud-Hansen[6] found gastrojejunocolic fistula to occur in one of seven individuals with marginal or recurrent ulceration.

Although most fistulas occur between the ages of 30 and 55, occurrences have been noted in a youth of 14[7] and as late as the eighth decade.

The sex ratio shows a striking preponderance of males. Marshall and Knud-Hansen[6] state that of more than 400 gastrojejunocolic fistulas reported by 1953, only 5 occurred in females.

Etiology

Gastrojejunocolic fistula is a serious complication of the surgical treatment of peptic ulcer. In most instances the original surgery was a posterior gastroenterostomy. In the Lahey Clinic series,[6] out of 49 cases, 38 followed posterior and 1 followed anterior gastroenterostomy. In Lowden's series of 46,[8] 39 followed posterior and two followed anterior gastroenterostomy. Skoog-Smith, Jaspin and Sullivan[7] reported 19 cases all following posterior gastroenterostomy, leading these authors to suspect that the anatomic hookup may play an important role in the development of the fistula. In speaking of the etiology, however, it must be remembered that the severity of the ulcer diathesis is basically responsible, either directly or indirectly, for all complications of peptic ulcer.

Pathology

The jejunal ulcer is the first step in the pathological sequence. It forms at the anastomosis or occasionally in the efferent loop. It is rarely found in the afferent loop, apparently because of the protecting influence of the pancreatic secretions. The ulcer is accompanied by inflammatory changes in the adjacent structures and dense adhesions form involving the colon, omentum and other viscera. This dense, adherent inflammatory mass confronts the surgeon attempting to correct the fistula, so that he is, as Gessler[9] stated, "ever reminded of his resolve to treat peptic ulcers conservatively

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as long as possible." The ulcer eventually erodes through into the colon and the fistulous tract quickly becomes lined with epithelium, so that even if a proximal colostomy or ileosigmoidostomy is performed, the fistula will not close off.

Symptoms

Diarrhea, weight loss, fecal vomiting and/or foul eructations are the commonest complaints. Fecal vomiting, in the absence of obstruction, is considered by Bornstein and Weinshel[10] to be pathognomonic of gastrojejunocolic fistula. Pain may be present in a small percentage of the cases. These patients will have 8 to 15 copious, watery bowel movements a day, the stools containing undigested food particles and occasionally mucus. Ten to thirty per cent of the reported series noted blood in the stools at times, but this usually did not reach alarming proportions. The weight loss is very striking and may amount to as much as 75 pounds[6] in long-standing cases.

These patients usually give a history of a period of freedom from symptoms ranging from a few months to 25 or more years, from the time of the original surgery. With the development of the marginal ulcer, they may experience pain which is more irregular than peptic ulcer pain and shifts to the left side of the abdomen in the region of the umbilicus. On formation of the fistula, the above-mentioned symptoms appear, and if pain were present, it usually subsides at this time.

Physical Examination

There is little in the physical findings to indicate specifically a gastrojejunocolic fistula. The patient will present an abdominal scar from his original ulcer surgery, of course. He will show evidence of weight loss and dehydration and, in the long-standing case, appear acutely ill. An abdominal mass is rarely palpable. Tenderness, distention and borborygmi may be present.

Laboratory Findings

Hemoconcentration is common and may mask the hypochromic anemia present in these individuals. The serum proteins are decreased, the albumin portion particularly. In general, the findings are those of malnutrition and electrolyte loss.

The chief diagnostic aid is the barium enema and fluoroscopic examination. The fistula was revealed by this means in 97 to 100% of three of the larger series.[6, 7, 8] The barium column is seen to pass up into the transverse colon and suddenly enter the stomach and jejunum. Upper gastrointestinal series, on the other hand, revealed the fistula in only 36 to 45% of the cases. The reason for this discrepancy has not been determined.

Treatment

Various procedures were attempted in the early years, chiefly (1) a simple closure of the fistula, (2) the same, with dismantling of the gastroenterostomy and re-establishment of normal intestinal continuity, and (3) closure of the fistula, dismantling the gastroenterostomy and formation of a new gastroenterostomy. It was felt that these severely malnourished, dehydrated and anemic patients were in no condition to permit a more extensive procedure. Even so, the mortality following these limited procedures was appalling, and most of the survivors had a recurrence of the ulcer or fistula.

Wilkie[11] is credited with using the first staged procedure, excluding the involved loop of colon in the first stage and later removing the excluded loop, dismantling the gastroenterostomy and re-establishing normal intestinal continuity. While the first stage was successful in reducing the mortality and resulted in a marked improvement in the patient's condition, the second stage was often followed by recurrence of the peptic ulcer or fistula, since the operation did not correct the ulcer diathesis.

Pfeiffer and Kent,[12] in 1939, published the results of their experiments showing that the reflux of irritating colonic contents into the stomach produced hyperperistalsis throughout the intestinal tract, and this was responsible for the severe diarrhea from which these patients suffered. They performed a proximal colostomy with, in most instances, an abrupt cessation of the diarrhea and dramatic improvement in the patient's condition. At re-operation three or four months later, they found the inflammatory process had subsided, making the second stage dismantling of the fistula much

easier. The colostomy was closed two weeks later.

Pfeiffer,[13] in 1941, reported 15 cases in which this three-stage method was used in five cases and in ten cases a subtotal gastrectomy was added. There was only one death in the series. Lahey,[14] in 1938, reported a two-staged procedure, the first stage an ileo-sigmoidostomy and the second, resection of the right half of the colon including the fistula, the involved portion of the jejunum and the distal two-thirds of the stomach, with end-to-end anastomosis of the jejunum and a Hoffmeister gastrojejunostomy. This procedure also brought about a marked reduction in mortality and in addition avoided the skin contamination of an open colostomy that accompanied Pfeiffer's method. These patients got along well in spite of the magnitude of the second stage.

It is generally agreed that the treatment of gastrojejunocolic fistula, to be successful, must meet two requirements: (1) remove the fistula and (2) attack the ulcer diathesis. Localio, Stone and Hinton[15] in reviewing 115 cases reported in the literature between 1943 and 1953, found a recurrence rate of 50% among those who had a simple disconnection of the fistula, whereas only 4% of those whose treatment included correction of the ulcer diathesis had recurrences. The staged procedures used by Pfeiffer and Lahey marked a tremendous advance in the treatment of gastrojejunocolic fistula. Nevertheless, a single operation that would meet these requirements with no increase in mortality would offer several advantages over the staged procedures. It would eliminate the hazard of two anesthetics and effect a considerable saving in time and expense to the patient. With the rapid advancement in pre- and post-operative care during the next ten years it became possible to do a one-stage operation with approximately the same mortality as the staged procedures. The single operation, after a period of two or three days spent in vigorous correction of the anemia, hypokalemia, starvation and dehydration, has become the treatment of choice.[6, 7, 15] The staged procedures are used in those patients whose condition is considered so desperate that they cannot be prepared sufficiently to withstand the extensive single operation.

Operation

The fistula is disconnected from the colon and if the defect in the colon is small, it is simply closed transversely; if there is much inflammatory reaction and induration, the inflamed loop is resected and an end-to-end anastomosis performed. The jejunal segment containing the stoma and fistulous opening is resected widely enough to remove all inflamed tissue and an end-to-end jejuno-jejunostomy performed. The distal two-thirds or three-fourths of the stomach, preferably with the portion of the duodenum containing the old ulcer site, are resected and the duodenal stump closed. An antecolic, Hoffmeister gastrojejunostomy is performed, the new jejunal stoma being located distal to the jejuno-jejunostomy constructed at the site of the original stoma. This puts the jejunal anastomosis in the afferent loop, where the decreased lumen at the suture line will not be in a position to obstruct the main alimentary stream.

Pre- and Post-Operative Care

The importance of this phase of the treatment cannot be over-emphasized. The nutritional deficiency cannot be corrected without operation and it has been found dangerous to prolong the pre-operative period. However, two or three days of intensive therapy will often bring about considerable improvement in the patient's condition, so that it is possible to proceed with the operation. Fluids and electrolytes (particularly potassium), amino acids and whole blood are given intravenously. It is unusual for one of these individuals to show a hemoglobin level below 12 grams[6]; they are so dehydrated that their hemoglobin determinations read deceptively high. Vitamins B and C are given in large doses and the patient is placed on a high carbohydrate, high protein and low residue diet. The bowel is prepared with antibiotics, neomycin with sulfathalidine being the current favorite.

Post-operatively, the intravenous fluids, glucose, amino acid hydrolysates, vitamins B and C are continued during the period of gastric intubation, and in decreasing quantities during the first few days of the usual graduated gastrectomy diet.

Case Report

N.J.A., a 49-year-old white male was first seen in the outpatient clinic (4-9-59), complaining of severe diarrhea of three weeks duration. It began with a bout of "intestinal flu," characterized by nausea, generalized aching, abdominal cramping, diarrhea and fever. The fever, aching and cramping cleared up after two or three days but the diarrhea persisted. He had from 10 to 15 watery bowel movements daily, containing undigested food particles and mucus. He also vomited occasionally, the vomitus having the odor and appearance of liquid feces. He belched frequently and his eructations had the same foul odor. He had lost approximately 12 pounds since the onset of illness.

He had undergone an operation for peptic ulcer in 1931. The remainder of his past history was not relevant.

Physical examination revealed a thin white male who appeared apprehensive but not acutely ill. The tongue was dry and coated and the skin appeared dry and tissue turgor was poor. The heart and lungs were normal, the abdomen was flat and showed a right upper rectus scar, the result of his ulcer operation. There was mild, diffuse upper abdominal tenderness, no masses or solid organs were palpated. Peristalsis was loud and hyperactive.

Urinalysis was normal, hemglobin - 13.8 grams, rbc - 4,800,000, hematocrit 44 mms., wbc - 7,650 per cu. mm. with normal differential. The serum proteins were 5.8 mgm% and the non-protein nitrogen 41 mgms%. On barium enema examination the barium was seen to pass up to the transverse colon and directly into the stomach. Upper gastrointestinal series performed on the following day showed the barium to pass from the stomach through a gastroenterostomy into the jejunum but it was not seen to enter the colon. No barium was seen to pass through the pylorus and duodenum. A diagnosis of gastrojejunocolic fistula was made and the patient prepared for operation.

He received intravenous glucose, amino acid hydrolysates, vitamins B and C and whole blood transfusions, over the ensuing three days. During this period he was placed on a high carbohydrate, high protein, low residue diet and for the last 48 hours prior to operation the bowel was prepared with a liquid preparation of neomycin and sulfathalidine.

At operation, the abdomen was opened in the midline from the xiphoid process almost to the umbilicus and after a mass of adhesions between the omentum and upper abdominal organs was dissected away, the fistula site was brought to view. It was found to connect the colon and the anterior margin of the gastroenterostomy. The connection to the colon was dismantled, and after dissecting away the indurated tissue, the opening was approximately 2 cms. long. This was closed transversely with a continuous suture of #000 chromic catgut



Figure 1

Spot film taken during barium enema reveals barium in transverse colon and filling stomach.

and reinforced with a row of interrupted horizontal mattress sutures of #0000 black silk in the seromuscular layers. The jejunum was transected through normal tissue on either side of the stoma and fistula, and an end-to-end jejunojejunostomy performed, using continuous #000 chromic catgut through the full thickness of the bowel walls, and an outer seromuscular row of horizontal mattress sutures of #0000 black silk.

Two-thirds of the stomach and the first part of the duodenum was resected, including the heavily scarred and stenotic portion of the latter which was the site of the original peptic ulcer. The duodenal stump was closed and an antecolic, Hoffmeister gastrojejunostomy performed. The new stoma was located approximately two inches distal to the jejunojejunos-

tomy described above. A Penrose drain was inserted with one end placed at the duodenal stump and the other brought out through a stab wound to the right of the main incision and the incision was closed.

Continuous suction through a gastric tube was maintained for 48 hours. Intravenous fluids, electrolytes, amino acids and glucose were continued through this period and during the next three days while the oral intake was gradually increased. The patient's temperature rose to 102 on the second post-operative day and ranged from 102 to 104 over the next three days. Penicillin and streptomycin were given and the temperature returned to normal on the 5th day, remaining normal throughout the hospital stay. The patient was discharged on the tenth day after operation and returned to the outpatient clinic four days later when the drain was removed. The patient gained weight and strength rapidly, and when last seen, three months after operation, was asymptomatic.

Summary and Conclusions

Gastrojejunocolic fistula is a serious complication of the surgery for peptic ulcer. It is a reflection of the severity of the ulcer diathesis.

The prototype of the patient with a gastrojejunocolic fistula is a male who has had a previous operation for peptic ulcer, probably a postcolic gastroenterostomy and who, after a period of good health, develops symptoms of marginal ulcer, followed by the sudden onset of a severe diarrhea with fecal vomiting, foul eructations and weight loss. Barium enema will almost invariably confirm the diagnosis of an abnormal connection between stomach, jejunum and colon.

The treatment of choice is to correct the patient's fluid, electrolyte and other deficiencies as rapidly as possible, then, at operation, dismantle the fistula and old enterostomy and do a subtotal gastrectomy with a new gastrojejunostomy. Any operation which removes the fistula but does not correct the ulcer diathesis is followed by a high rate of recurrence and prohibitive mortality. Staged procedures, using as a first stage Wilkie's colic exclusion, Pfeiffer's proximal colostomy, or Lahey's ileosigmoidostomy are used in those cases whose condition is so grave that they cannot be prepared in a short time to tolerate the single stage operation. Here, as in other types of surgery, the treatment must be altered to meet needs of the individual patient.

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Our Aging Population*

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THE magnitude and diversity of the problems of our aging population is being studied with increasing interest and concern by the medical profession, the public, and State and Federal agencies. There have been many local, national and international conferences on aging. Societies and national committees have been formed. Several of the medical journals, devoted to the subject, are well established. At least one, *Geriatrics*, is in its thirteenth year. The tremendous extent of the literature can be appreciated when note is taken that there are more than 70,000 references listed on the subject. To say that there is an increased awareness of the problems of an aging population is a gross understatement.

The problems are, by no means, confined to the biological sciences and clinical medicine, as the social, economic and enviromental aspects are of equal importance. Too often the public is prone to assign the problems of the aging population to the medical profession, and the physician is too busy to appreciate the geriatric patient as an individual with as many, or more, social and economic problems as medical. We, as physicians, will be asked for advice and guidance by patients, families, employers and the public. The medical profession should be concerned with the problems of aging beyond their purely health aspects. Anticipating old age with assurance calls for good health, financial security, good social adjustment and a receptive environment. A total approach is necessary.

Life Expectancy

That we are rapidly adding years to life is borne out by studies. For more than a century, the average length of life in our country has been steadily increasing. In 1850, life expectancy at birth was less than 40 years with approximately 1,000,000 people over 60 years of age. Life expectancy has now risen to 70 plus years and the "over 60" population to 20 million. Two out of three men, now over 20 years of age, and more than four out of five women are expected to survive beyond their 65th birthday. We are truly confronted with an age of the aged.

The causes of the increased longevity can be traced to:

1. Higher living standards with better nutrition, better clothing, shorter working hours and the like.
2. Public health measures with safe water, safe milk, food inspection and sewage disposal.
3. Effective control over diseases of environmental origin, the common infectious diseases, and decreased infant and maternal mortality.
4. Better diagnostic methods, better hospitals and improved medical education.
5. The greater skill and knowledge of all members of the health sciences, physicians, dentists, nurses and laboratory technicians.

The composition of our older population is important to appreciate. Currently, white men at age 65 can be expected to average 13 additional years and white women, 15 years. The present sex ratio is 116 females per 100 males. By 1975, the estimate is 138 women per 100 males. More than half of the older women are widowed, while one-fourth of the men are widowers. A considerable per cent spend their later years in living arrangements apart from their families and relatives. The educational background of those above 65 years shows only 30 per cent have more than a grade school education and more than 20 per cent have less than five years of formal schooling. Only 45 per cent of the men above 65 years of age are employed and only 10

* *Read at the seventh Committee District Meeting June 25, 1959 — Frankfort, Ky.*

per cent of the women. With the present legislation, these figures on employment are rapidly declining. These figures show a tremendous manpower pool that is unproductive, a dependent group without husband or wife, without education, without economic security, without protection of the family group and living accommodations. This presents an overwhelming problem to us all.

Social and Economic Problems

In the past century, old age has lost respect and sympathy. Old age has been deprived of its rarity, and the rapidly changing technology in an industrial era has devalued experience. The change from a rural to an urban society has undermined the importance of the role of the senior citizen as the carrier of the tradition of experience and wisdom.

The present-day home hardly accommodates a two-generation family, much less three generations, and thereby fails to provide the security and familiarity of a home setting to its aged members. The major factors associated with good adjustment in old age are love, affection, security, housing, intellectual and physical occupation for mind and body, companionship and probably above all, a sense of being understood, appreciated and wanted. All of these factors are now threatened.

Three aspects of old age of grave concern to the individual are maintenance of income, maintenance of health, and maintenance of social adjustment. If any of these factors are woefully deficient, the chances of growing old gracefully are poor.

Maintenance of income is probably the major factor of concern for the aged and the magnitude of the economic problems can hardly be overemphasized. Provisions for continued or new employment are, I believe, necessary. Compulsory retirement at the age of 65 is, in my opinion, illogical as no consideration is given to personal desires and psychological and social needs of the person and no regard is given to his productive capacity. A physician, without better means than now exist, should not be put in position of being judge and arbitrator in decisions concerning employee retirement. Most men need to, and probably would prefer to, continue working after 65. The answer to the income problem has not been found and I doubt if it is to be found in present and proposed legislation.

Health Problems

Maintenance of health is the part that more directly concerns us. I would like to discuss some general methods of treatment. There should be sympathy and understanding. Everybody in attendance should understand that the comfort of the patient takes precedence over all other factors. If the illness is acute and curable, ordinary methods of treatment should be applied even if the patient is reluctant to accept them, but if the illness is incurable and likely to be chronic, attention should be given to those procedures which may restore the patient's ability to look after himself. Getting an old patient out of bed and into a chair often seems a waste of time and effort and is sometimes resented by the patient but it sometimes results in the patient walking again.

Meddlesome diagnostic procedures in the elderly patient should be avoided and scientific curiosity left unsatisfied. The patient of 80 with arteriosclerotic heart disease and a mass in the chest which may be inoperable carcinoma will not be helped by the diagnosis being confirmed by bronchoscopy. The only persons helped, by doubt being changed to certainty, are the doctor and the relatives. Common sense and ingenuity are important in dealing with old people. One might well be guided by Mark Twain's statement when he said, "Habit is habit and not to be flung out the window by any man, but coaxed downstairs a step at a time." These people can often be coaxed but seldom can you drive them.

When patients become bedridden, special attention should be given to what McDonald describes as the four B's — back, bladder, bowel and brain. The prevention of bed sores is most important. We all know how hard they are to cure. Urinary incontinence is always a problem interfering with the patient's rest as well as increasing the hazards of bed sores. If it is not the result of prostatic or neurological disease, it may be lessened by regular and frequent bladder emptying and getting the patient up when possible. In women, pelvic abnormalities are often responsible. Retention catheters are often necessary, at least at intervals.

Constipation is a trying problem with many old people. It can, perhaps, be lessened by fluid regulation. As far as the use of laxatives is concerned, it is usually my policy to let them take whatever they have been taking and have found most effective. This covers a wide range of preparations and procedures but if it works we are both happy. If it does not, then more specific orders are given.

Between-meal fluid intake should be ordered unless it is necessary to restrict fluids. If this is necessary, then minimum and maximum quantities should be set.

Fecal impaction often occurs and it should be examined for, particularly if the patient is dehydrated or distended. In my experience, enemas, when the impaction is firm, are practically useless and the only effective treatment is to dig it out manually, however painful and unpleasant this is.

Helpful Procedures

The brain should never be forgotten even though tremendous effort is required to keep a patient interested and occupied. Try to find something, however simple, that the patient is, or can become, interested in. The best of healers is good cheer. Physiotherapy cannot be overemphasized although we often neglect it. Even simple massage and back rubs help. These procedures not only help, physically, but also suggest to the patient that there is some hope. A bedridden and apparently helpless old person can sometimes be helped to the point when he can attend to his simple wants.

The mental changes with aging often bring to mind a person with failing memory for recent events, whose memory for past events remains fairly intact, who is cross, irritable or apathetic, asocial and with a diminished capacity for self-care and a neglect of personal appearance. There is often, also, a tendency to self-indulgence and paranoid ideas. These are often accepted as inevitable although all of us know many examples of persons who have staved off this deterioration for many years. These changes are quite understandable, however, when we realize the rejection of the aged by their families and society in general.

We are using our mental hospitals as depositories for individuals no longer wanted or tolerated by society. Let us hope that the newer drugs will help bring about a solution of the overcrowding of our psychiatric hospitals and also the intra-hospital problems arising in the senile psychotic.

Psychological Adjustment

The third big problem for the aged is social and psychological adjustment. With compulsory retirement, the inability to find new employment, the frequent breaking up of the home and loss of husband or wife, the loss of friends through death, the moving into a strange environment, the sense of not being wanted, and the loss of self-esteem, the old person is faced with a tremendous strain on his ability to adapt. Those well-adjusted people who could meet crises in their younger days will probably meet the new ones with comparative efficiency. The inadequate will either deny his inability to adapt, repeating, or even exaggerating his acts, or withdraw within himself and spend his days talking about the past when he was happier. He then blames his failures on lack of understanding, sympathy or intelligence in the social situation around him.

These are the problems the patients bring to us as physicians. They are hard and sometimes impossible for us to solve. We, in some respects, are in a favored position. We face no compulsory retirement or new employment. If we retire or change location it is our own choice. Our self-esteem and dignity are seldom challenged.

With these people we should attempt to recognize, then understand their physical and mental capacities as well as we do their incapacities.

Study of Geriatric Patients Admitted To Central State Hospital*

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IN less than twenty years in the United States the population of people age 65 and over has increased by approximately six million.[1] This increase represents more people than the combined total of the population of the states of Arkansas and Kentucky.

With this rapid growth in population, there must be an increasing public consciousness of the ever-growing problem of providing adequate and suitable medical and nursing care for geriatric patients. Many elderly persons are committed to mental hospitals, indigent wards, or over-crowded nursing homes simply because there is a glaring lack of facilities, and too often friends and relatives do not wish to be burdened with the care of such persons.

This study, conducted at Kentucky's Central State Hospital, a hospital chiefly concerned with mental illnesses, deals with patients 65 and over who were admitted to the hospital during the summer months of 1957 and 1958. The results, with startling clarity, emphasize the problem of geriatric care which exists in many areas.

The study consists of follow-up research on patients admitted to the hospital during the summer of 1957 and continued research with geriatric patients admitted to Central State during the summer of 1958. A careful investigation was conducted concerning the method of admission of the patients and the circumstances that warranted their admission to the hospital, without regard to clinical impressions.

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***Senior Student, University of Louisville School of Medicine. This work was done under a U.S. Public Health Grant and was conducted under guidance of Walter Fox, M.D.*

Method of Research

The principal research instrument utilized was the technique of the personal interview. The follow-up research included personal interviews with the twenty-six (26) patients still living of the 40 originally interviewed in 1957. In the study of new admissions, which was conducted from June 15, 1958, to August 21, 1958, forty patients out of 163 admissions (25% of all admissions) were 65 years of age and over. These patients were interviewed at the time of admission, as were their relatives and/or friends. In cases when the patient was not accompanied to the hospital by a relative or friend, every effort was made to locate the patient's family and interview them personally, or contact them through Social Service.

In addition to information gained from the personal interview, data was collected from Social Service records, hospital charts, and from staff conferences at which the diagnosis and disposition of patients were discussed.

An objective interview form was prepared and in each case the individual's responses carefully recorded and evaluated. Information was compiled concerning the personal, family and medical history of each patient as well as the pre-admission behavior which had contributed to admission. An analysis was also made of the patient's relationship with his family, and of the family's financial resources. It was the task of the interviewer after careful study and evaluation to judge whether the patient's admission to and continued stay in the hospital was justified, not justified, or of questionable justification.

Justified admissions included only those patients who, after a period of observation on the ward, were judged to be suffering varying

degrees of definite mental illness. Admission was considered *not justified* when after a period of observation a patient gave no evidence of any psychotic disorder, but merely demonstrated effects of the normal aging process. In a few cases where patients were still under staff observation at the conclusion of the study, the admission was classified as *questionable.*

Results of Study

The first study (conducted from June 17, 1957, to September 5, 1957) was concerned with forty patients (19.7% of all admissions) age 65 and over.[2] The patients were interviewed at the time of admission, as were their friends and relatives. The study concluded that of the forty (40) admissions, only 45% were justifiable admissions with definite need for mental hospitalization. It reported that 37.5% of admissions were questionable as to justification, because there existed a divergence between the admissions picture and the pre-admission history, and 17.5% of the admissions were definitely not justified. This indicated that many geriatric patients in need of nursing or medical care, but not mental hospitalization, were admitted to Central State Hospital.

The 1957 study also indicated that 57.5% of the geriatric patients interviewed had experienced some definite difficulty with early life adjustment. The term *early life adjustment* included the pre-senile adjustment of the patient.

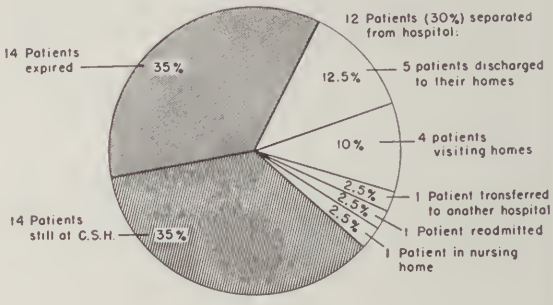
The accompanying diagram portrays what happened to these forty patients during the period of one year.

A vital part of the 1958 study was the investigation of the channel or method of admission of each patient to the hospital. It is possible for patients to be admitted to Central State Hospital through a variety of channels. The following types of admissions were recorded during this study:

(1) By voluntary admission—Five patients (12.5%). When entering voluntarily the patient signs a request for admission, stating that he believes he is in need of psychiatric hospitalization.

(2) By medical certification—Twenty patients (50%). When a patient is admitted by medical certification, family or friends of the

DISPOSITION OF 40 PATIENTS ONE YEAR FOLLOWING STUDY



patient complete and sign an application, and two physicians (after examining the patient) state the need for hospital care.

(3) By order for 35-day observation—Seven patients (17.5%). Under this method of admission, two physicians sign a form stating the need for immediate hospitalization and further observation needed for diagnosis.

(4) By warrant of arrest—Seven patients (17.5%). After petition has been filed by a relative or friend, the patient is sent to the hospital, and later examined by two court-appointed physicians to determine whether or not he is mentally ill.

(5) By health officer admission—One patient (2.5%). Under this method of admission, a licensed health officer signs the form requesting hospitalization for fifteen (15) days.

Inquiry as to members of the family who were responsible for the patient's admission to the hospital revealed that sixteen males (81%) were brought to the hospital by a close relative such as son or daughter, brother or sister, or wife; likewise seventeen females (79%) were brought by close relatives.

An evaluation was also made of the early or pre-senile life adjustment of each patient to determine his ability to adjust in his past life. Criteria for evaluation were established under three broad categories—normal adjustment, borderline adjustment, and maladjustment. Definition of these categories is as follows:

(1). Normal adjustment — An individual was regarded as having made normal early life adjustment if he had done well in school, held a steady job, had an adequate family life, and gotten along well with his friends and neighbors.

(2). Borderline adjustment—This category

includes those who had difficulty in school, were withdrawn, had been divorced or had unhappy family experiences, and had shifted from one job to another. Two or more of these factors warranted this classification.

(3). Maladjustment—In this category were placed those persons who had history of previous mental hospitalizations, alcoholism, jail records, multiple marriages, and/or no job adjustment. Two or more of these factors designated a person in this classification. Table No. 1 shows the percentage of geriatric patients in each category, together with an evaluation as to the justification of their admission.

The ages of the patients interviewed were also recorded, and ranged from 65 to 89 years. Eighteen (49%) of the geriatric admissions were in the age group from 65 to 70 years.

The average length of illness prior to admission of the patients was less than one year in 37.5% (15) of the cases; however, seventeen patients (42.5%) had been ill from one to five years prior to admission.

It is also interesting to note that a major part of the group (28 patients representing 70%) were being admitted to Central State Hospital for the first time. Only seven patients (17.5%) were entering the hospital for the second admission, and only five had a history of three or more admissions.

TABLE NO. 1

Analysis of Early Life Adjustment

		Justifiable Admission	Non-Justifiable Admission
Normal Adjustment	14 (35%)	3 (20%)	11 (80%)
Borderline Adjustment	7 (17.5%)	2 (30%)	5 (70%)
Maladjustment	11 (27.5%)	10 (91%)	1 (9%)
Insufficient Information Available	8 (20%)	5 (63%	3 (37%)

The question often arises concerning the role of hereditary and familial factors in mental illness. Such a role cannot be defined or substantiated in this small sampling of patients. Eight of the families (20%), however, reported a history of some other mental illness in the family. The accuracy of these figures is questionable, since some families are reluctant to discuss any type of nervous disorder which has occurred in the family.

Discussion

As figure one illustrates, only fourteen patients are still at Central State Hospital, but it is particularly interesting to compare the similarity of the observations that were reported during the summer of 1957 with those made during the summer of 1958. Table No. 2 compares the percentage of admissions of these patients which were felt to be justified in 1957, with the number for which continued hospitalization was felt to be justified during the summer of 1958.

TABLE NO. 2

Analysis of Fourteen Patients Still at Hospital

	Flowers—At time of Admission, 1957	Peters—Follow-up one year later, 1958
Admission Justified	7 of 14 (50%)	5 of 14 (36%)
Admission Not Justified	7 of 14 (50%)	7 of 14 (50%)
Admission Questionable	None	2 of 14 (14%)

It is of particular importance to note that one-half of these patients were simply affected by the normal aging process with moderate loss of memory associated with Chronic Brain Syndrome; therefore, they could have received care in a less specialized facility and their admission and stay in a mental hospital was not justified. Of the seven previously evaluated as justifiable admissions, only five are deemed so at this time. Therefore, two patients after one year of hospitalization have reached the state of non-justifiable or questionable justification of stay at the hospital. The fact that 57.5% of this group of patients had experienced some difficulty with life adjustment also points up the need for more intensive work directed toward the early prevention of mental illness.

In the 1958 study of the various methods of admission, the alarming circumstances were those concerning patients admitted on warrant of arrest. Thirty-five per cent (35%) of the patients interviewed were admitted on some type of warrant. The causes for warrant included only one incident of outright violence on the part of a patient toward his family. A number of patients admitted by warrant simply

had become physically disabled and were no longer wanted at home, but were in dire need of nursing care. In fact, a majority of the patients admitted by warrant of arrest had some need for nursing care; however, some cases could have been adequately cared for in their own homes.

The percentage of admissions, especially by warrant of arrest, may indicate that the law concerning the placing of aged people in mental hospitals is being exploited to some extent. This is evidenced by the increasing demands upon courts of law to commit elderly people who are no longer able to care for themselves. It would be a logical sequence of events to require more rigid observation and psychiatric evaluation *prior* to admission rather than afterward.

It was also observed that since plans for the patient's rehabilitation and eventual home-going were not discussed prior to admission, this sometimes resulted in the patient's being forgotten by his family. It is easier for the hospital staff and social service workers to establish rapport with the family if the patient's welfare is discussed prior to his admission to the hospital by court order.

Using Table No. 1, if we combine the borderline cases (17.5%) and the maladjusted (27.5%), we see that 56% of the patients on whom background information was available experienced definite difficulty with early life adjustment. Ten out of eleven of the patients who were designated as maladjusted were justifiable admissions to a mental hospital. These figures strongly support the observation that inability to cope successfully with the stresses of early life contributes to mental illness in later life. This indicates the need for adequate adjustment to the early stresses of life as a means of preventing adjustment difficulties in the later years of life.

Many of the patients were not diagnosed at time of admission (regardless of history given at time of admission as to pre-admission behavior), but were observed on the wards, with the final decision being reached in a diagnostic staff meeting including an interview with the patient.

A majority of the group studied were geriatric patients who suffered some loss of memory, were in a mildly confused state, and were primarily dependent upon their families. In this group were twenty-seven cases (65%) who were diagnosed as Chronic Brain Syndrome due to senility or cerebral arteriosclerosis. Presumably these patients were without psychosis. Six cases (15%) were diagnosed as Chronic Brain Syndrome with psychotic reaction. Seven patients (17.5%) were diagnosed as having various other psychotic disorders at the time of admission. One patient was diagnosed as cardiovascular accident and was considered to be strictly a nursing problem. His presence in a mental hospital was not warranted by any of the circumstances.

An attempt was also made to evaluate the financial status of the patients and their families to determine those who had available resources and those where there existed a favorable attitude regarding the future of the patient. In evaluating financial resources, consideration was taken of social security income, pensions, income from property owned by patients, plus funds that families were able to contribute. Twenty-nine of the patients and/or their families (72.5%) did have ample funds to meet the cost of nursing care elsewhere.

It is particularly important to note that nine of these twenty-nine patients were non-justifiable admissions, their families had favorable attitudes, and they would not be in a mental hospital if they had been more carefully screened prior to admission and channeled elsewhere. This is rather conclusive evidence for the need of psychiatric evaluation prior to admission, for it becomes increasingly difficult to obtain a family's co-operation after a patient has been committed to a mental hospital.

It is encouraging that there is an increased and growing interest in the building of community nursing homes and hospital wings which provide well-rounded programs of rehabilitation and medical care for geriatric patients. Examples of such projects which have recently been put into operation successfully are the Chilton County Hospital in Clanton, Alabama,[3] the Coronado, California, Hospital,[4] and the Alleghany County Hospital in Pennsylvania.[5] Such projects should be encouraged in every community.

Summary and Conclusions

One of the primary purposes of this study was to ascertain whether or not the geriatric admissions to Central State Hospital were justified admissions. After observing the patients on the wards, twenty of them (50%) were adjudged as non-justifiable admissions. The remaining twenty patients (50%) were deemed to be justified admissions after they had been observed over a period of time. Since half of the admissions were not suffering from definite mental illness, but were in need of nursing care, this emphasizes the need for nursing homes and hospitals where such patients can be cared for properly.

If patients were more carefully screened prior to admission, the hospital facilities at Central State Hospital would be of greater benefit to more of those who are justifiably there. It would require no more personnel to channel geriatric patients who are simply nursing problems to available nursing homes (especially in cases where finances are adequate). The result would be a more well-rounded program and more adequate medical care for such patients than can be expected in an already overcrowded state hospital.

It is of paramount importance that similar studies be conducted in other mental hospitals in order to verify or dispute these tentative conclusions.

There is also need for intensive investigation into the varied type of facilities that are now in use in various communities for the care of geriatric patients, in order to determine what type of facilities provides the best care for such patients, and how these can best be incorporated into community life.

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2. 1957 study conducted by Jerry Flowers, senior student, University of Louisville School of Medicine.
3. See "These Long-Term Care Units Meet a Growing Community Need," in *Hospitals*, Journal of the American Hospital Association, July 1, 1958.
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Acute Dissecting Aneurysm of the Aorta

Surgical correction of dissecting aneurysm of the aorta is now possible. The exact diagnosis of this condition is therefore more important than ever. The histories of 11 patients who underwent surgery have been analyzed in order to identify retrospectively the symptoms and findings most valuable in establishing the diagnosis. The most important was a history of very severe pain which usualy radiated to the back and frequently moved from its original location to another area; it was more severe than the pain of myocardial infarction and particularly significant in the absence of electrocardiographic abnormalities. Roentgenograms were of critical importance in 9 of the 11 cases, especially in one instance when the aortogram showed a double-barreled lumen. A difference in the peripheral pulses was present in 6 cases. Systolic murmur, abdominal bruit, and an abdominal mass occurred in less than half of the cases, but were helpful diagnostic points when they did occur. Four of the 11 patients survived surgery and did well after operation. Although the mortality in this series was high, the risks of allowing acute dissecting aneurysm to go untreated are so great that the authors advise prompt operation as soon as diagnosis is established.

Julian R. Beckwith, M.D.; William H. Muller, M.D.; W. Dean Warren, M.D., and J. Edwin Wood, Jr., M.D., AMA Arch. Int. Med., August, 1959

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital*

Iatrogenic Blindness?

Horace W. Addams, M.D.† and Richard C. Turrell, M.D.‡

A 73-year-old Negro female was admitted to the hospital on October 6, 1959, complaining of loss of vision. Her health had been fair until October 4, 1959, when she became weak, pale and was noted to be groping for objects. When she was seen by a physician the next day, her blood pressure was 80/60 and she could only distinguish between light and dark.

After sleeping all night in a sitting position, she was discovered on the day of admission with slurred speech and confusion. At this time, jerking movements of her left extremities, lasting seconds, were followed by weakness of the left hand. Hospital admission was accomplished shortly thereafter.

Past History

For several years the patient had been troubled with aching and soreness of her large joints. Prednisone in combination with aspirin was taken intermittently for flare-ups of this "rheumatism." In March, 1959, she was placed on a Rauwolfia preparation for an established asymptomatic hypertension of many years duration. Beginning in June, 1959, and recurring almost weekly she developed episodes of lightheadedness, generalized weakness and dim vision. All occurred when standing and could be quickly relieved by recumbency. Persistent epigastric pain associated with tarry-colored bowel movements appeared in the week before admission. Food and alkalis gave incomplete relief of this pain.

Physical Examination

Temperature 98.6°F., pulse 88 per minute, respirations 22 per minute and blood pressure 150/175. The patient was normally developed and nourished but appeared very pale, especially in the conjunctiva, nail beds and mucosal surfaces. She was awake, but speech seemed slurred and her head and eyes were turned to the right. Pupils, measuring 4 mm. each, reacted very slightly to light, and only light perception was present. A mild weakness of the left extremities, estimated to be about 15 to 20 per cent, was noted. Reflexes were increased on the left side and there was a suck, snout and bilateral extensor plantar response. A grade two systolic murmur was heard at the cardiac apex. Tarry stool was found in the rectum, but no masses could be felt. Skin, lymph nodes, ears, nose, throat, abdomen and pelvic examination were normal.

Hospital Course And Laboratory Work

Admission laboratory work revealed a hemoglobin of 4.1 gm.%, hematocrit 12%, white blood count 22,100 with 70% polymorphonuclears and 30% lymphocytes. Urinalysis showed a specific gravity of 1.008, negative albumin and sugar. Blood urea nitrogen was 43 mg.%, chlorides 110 mEq./L., carbon dioxide 18 mEq./L., blood sugar 71 mg.%. Fifteen hundred cubic mm. of whole blood was administered intravenously and within 12 hours there was marked improvement. Vision returned to normal and the left hemiparesis and head-turning disappeared. A recheck of the

LGH No. 336901

From the Sections of Neurology and Electroencephalography, University of Louisville School of Medicine
† *Neurology Resident*
‡ *Assistant Professor of Neurology*

hemoglobin on October 7, 1959, was 7.9 gm.%, and by October 12, 1959, had risen to 10.5 gm.%. Positive examinations for blood in the stool were repeatedly found.

Chest and skull X-rays were normal. X-rays of knee joints revealed changes characteristic of chronic osteoarthritis. An upper gastrointestinal examination with barium revealed deformity of the duodenal bulb and two separate prepyloric ulcers.

By October 10, 1959, she was asymptomatic, afebrile and ambulatory. Her management consisted of ulcer diet with antacids; dilantin and phenobarbital because of initial focal seizures; and withdrawal of steroids, aspirin and Reserpine.

Discussion

In the present era of potent therapeutic agents it is not enough for a physician to be aware of the natural history of disease. Additionally, he must be on guard for factitious, iatrogenic and patient-aggravated disorders.

The case presented today of compounded events that led to the production of severe blindnes may be an example. For purposes of this discussion I will limit myself to the iatro genic and patient factors evident.

Essentially, this is an elderly hypertensive lady with aged blood vessels and joints who developed blindness, seizures and left hemiparesis secondary to shock from gastro-intestinal hemorrhage. Possible accompanying and antecedent causal factors included Reserpine, aspirin, steroids, diseased blood vessels and upright sleep.

Proceeding chronologically, a few words should be said about the treatment of fixed chronic hypertension in an older person. It has been shown in a small series of carefully followed hypertensive patients over the age of 60 years that the mortality rate in treated and untreated groups is no different[1] and, therefore, treatment with antihypertensive agents is not indicated. Even more serious are the frequent disastrous effects of lowering blood pressure in this age group, particularly when signs of cerebrovascular insufficiency have voiced themselves.[2] Data from Fazekas[3] suggests that subjects with cerebrovascular disease in many instances are unable to compensate for reductions of blood pressure and develop signs of cerebrovascular insufficiency at higher pressure levels than normal subjects.

In our patient, warning symptoms referrable to the vertebral-basilar circulation (e. g., lightheadedness, dim vision, generalized weakness) became evident shortly after she was placed on a Rauwolfia compound. At this point the discerning physician would have discontinued the treatment.

Adrenal steroids have little indication in the management of orteoarthritis and are usually frowned upon by rheumatologists except for an occasional intra-articular injection.

The long administration of Prednisone could well have produced the ulcerations in the patient's upper gastro-intestinal tract and the ensuing hemorrhagic shock.[8] All of the steroid preparations including the newer refined forms have the propensity to ulcerate the upper GI tract, particularly when chronically administered. Furthermore, when the patient stopped taking steroids she may have been in a state of relative adrenal insufficiency, with a poor response to the challenge of severe gastrointestinal hemorrhage.

Acetylsalicylic acid is known to reactivate existing ulcers and it may have made a contribution here.

Overt gastrointestinal bleeding, in the week prior to admission, further reduced the patient's oxygen-carrying capacity, and also aggravated the existing relative hypotensive state.[2] Rauwolfia[5] compounds should again be mentioned as a double villain. Not only may they precipitate serious hypotension, but they are known to activate peptic ulcers by increasing the volume and acidity of gastric secretion. Hematemesis and melena have been repeatedly reported as complications of Rauwolfia alkaloid therapy.[4]

Just prior to the onset of blindness, the patient slept overnight in an upright position.[2] It has been shown that there is a significant fall in blood pressure during sleep that is potentiated by the upright position.

Amaurosis following hemorrhage has been reported by several authors.[6] Extreme sensitivity of the retinae to hypoxia has been given as an explanation by some,[7] but an additional factor of pre-existing basilar artery disease with marginal blood flow to both occipital lobes was also present in our case. This patient's

(Continued on Page 82)

wherever there is inflammation, swelling, pain

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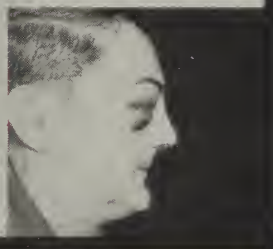
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1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

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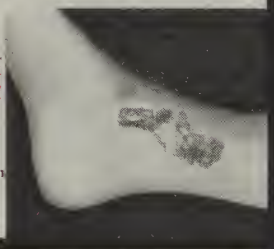


FORCE INJURY
severe bruises
... swelling
... cleared
by fifth day[2]





VARICOSE
ULCER
15 years duration
... resolved with
VARIDASE[1]





INFLAMMATORY
DERMATOSIS
rapidly spreading
rhus dermatitis
healed within
a week[1]





INFECTED
LACERATION
arked reversal
in 3 days...
returned
to school...
sure advanced[1]





THROMBOPHLEBITIS
back on his feet
in a week after
recurrent episode[1]





REFRACTORY
CELLULITIS
normal routine
resumed after 4 days
of VARIDASE[1]



SPECIAL ARTICLE

The Place of Drugs In the Practice Of Medicine And Surgery, 1809 and 1959*

Glenn Sonnedecker**

THE spirit that makes Ephraim McDowell memorable in American medicine will never be outmoded among men of aspiration and courage. His claim to greatness lies not only in a single, brilliant operation, nor even in pioneering the broader field of abdominal surgery. It lies also in his independent thought, in facing challenging circumstances, in his courage coupled with compassion.

You here in Kentucky, by restoring McDowell to a more tangible and popular remembrance, make all who pass this way aware of his contribution and of his enduring qualities that surmount barriers of unfavorable conditions and the discussion of commonly accepted and respected opinion. For that, on behalf of the members of the American Institute of the History of Pharmacy, I thank each one who helped bring this project to the successful conclusion we mark here today.

Practiced Medicine and Pharmacy

We are reminded that when McDowell opened his establishment in 1795, young America could not take over intact the medical system of countries long-matured. In Europe, pharmacy had long since become a separate and professionally structured specialty in the health field. In the United States, medicine and pharmacy usually were practiced by the same person, as we find in societies of a more primitive cultural stage, often with medical practice associated with the priesthood or clergy as well.

Like most other practitioners of his time, Ephraim McDowell practiced pharmacy as well as medicine, and even kept a public drug shop. Therefore, every pharmacist, as well as physician, may feel a lineal link with this remarkable man.

As I understand it, the Kentucky Pharmaceutical Association got solidly behind the Medical Society's vision of the McDowell shop restored and refurnished. Locally, you have been fortunate to have a pharmacist of the intelligence, energy and conscience of George W. Grider to help give that vision reality. For counsel he had the open-handed advice of the pharmacist, George B. Griffenhagen, a museum expert with the Smithsonian Institution. And it was a retired pharmacist of Connecticut, Sydney Blumberg, the collector, who brought together so much of the equipment and shelfware needed.



The remarkable progress of drug therapy since Dr. Ephraim McDowell's "daring feat of surgery" 150 years ago was outlined by Dr. Glenn Sonnedecker, director of the American Institute of the History of Pharmacy and associate professor at the University of Wisconsin, one of the featured speakers at the McDowell Apothecary Shop dedication in Danville last August 14. The seeds had been sown and partly sprouted in McDowell's time, he said.

It is pleasant to learn further that both men and firms of the pharmaceutical field, not only within Kentucky but beyond, had a cultural impulse strong enough to make it all financially possible. Conjointly these pharmaceutical efforts thus honor the physician-pharmacist Ephraim McDowell and the obligation of teamwork in the health field.

The restored apothecary shop, I am told, even may have been the first pharmacy, recognizable as such, west of the Allegheny Mountains. This, of course, was long before graduation in pharmacy—or even in medicine—was required to practice pharmacy, as a matter of public protection. It was more than seven decades before the Louisville College of Pharmacy opened its doors (1870), which later became part of the University of Kentucky. It would be

(Continued on Page 65)

**Presented at the dedication of the restored McDowell Apothecary Shop at Danville, August 14, 1959.*

***Director, American Institute of the History of Pharmacy; Associate Professor, University of Wisconsin.*

The Effect of the McDowell Operation On the Growth of Surgery*

John C. Burch, M.D.**

ONE hundred and fifty years ago, Dr. Ephraim McDowell performed his famous operation on Mrs. Jane Todd Crawford. This initiated a new and shining era in surgical history. It is fitting that in this sesquicentennial year, we should see the restoration of his apothecary shop. Here Doctor McDowell spent the greater part of his professional life; here he interviewed Mrs. Crawford, and some authorities contend that in this very room he performed the history-making operation.

To me the apothecary shop represents the inseparable bond between medicine, surgery and the pharmaceutical professions. Doctor McDowell was physician, surgeon and apothecary. The jealous few who attempted to disparage him sometimes referred to him as "a pretty fair surgeon but not much of a fever doctor." Unfortunately, there is no other record as to his skill as an apothecary.

A layout of pictures taken at the Ephraim McDowell Commemorative Stamp celebration, held in Danville on December 3, appears on Page 77.

Gentlemen of the pharmaceutical profession, we are fully aware of the great role you have played in the alleviation of human suffering. We are grateful for the contributions you are making and for your unselfish dedication to research in the basic sciences as well as your brilliant contributions in pharmacology. You have provided humanity with new knowledge and opened new horizons for longer, healthier and more useful lives. We thank you, too, for making possible the restoration of this apothecary shop.

One of my functions today is to bring you the greetings of the Fellows of the Southern Surgical Association and to pay their respects to the memory of the great surgeon, Ephraim McDowell, the patron saint of the Southern Surgical Association.

His likeness forms the central portion of the great seal of our association, and this emblazons every volume of our transactions and all of our official correspondence. Our transactions contain many references to Doctor McDowell and one can not fail to be impressed by the number of Fellows who have contributed articles on the life and work of this great surgical hero.



Surgical history's "new and shining era" was inaugurated by the McDowell operation, said John C. Burch, M.D., professor of gynecology at Vanderbilt University, in an address at the dedication of the McDowell Apothecary Shop in Danville last August 14. "In studying McDowell, surgeons find their ideal," he stated.

To me the occasion is also a most pleasant one. It recalls memories that I like to cherish. Years ago, I remember my father working over his address for the centennial of Doctor McDowell's death. On my first visit to this historic shrine, Dr. Dan Elkin was my guide. My last conversation with Doctor Elkin was about this house. As an ovariotomist of sorts, I also find it very pleasant to laud the one who showed us the way, the father of all ovariotomists.

Role In Surgical Development

To us it is perhaps strange that at Doctor McDowell's death, and even for some years thereafter, there was no general recognition of the importance of his contribution, but with the passage of the years his fame has increased and yet I doubt if we see him now in all his true greatness. In order to understand this, it is necessary to consider Dr. Ephraim McDowell's role in the development of the surgery of today.

**Presented at the dedication of the McDowell Apothecary Shop at Danville on Friday, August 14, 1959.*

***Professor of Obstetrics and Gynecology at Vanderbilt University.*

At the beginning of the 18th Century, surgery was largely a mechanical art and its practitioners were often crude and unskilled. Due to advances in anatomy and the accumulation of knowledge, things began to change. In the English-speaking world, the outstanding figures in placing surgery on a scientific basis were the Hunter brothers of London. Garet Robers has recently dramatized the life of John Hunter in a best selling novel called "Lacet."

Ephraim McDowell was born when John Hunter was in his prime. It was to Hunter's influence that surgery was then beginning to develop as a science based on anatomy and physiology. Hunter was the first really great surgical investigator. His great curiosity inspired a series of investigations which form the solid base on which surgery is continually developing new techniques for the relief of hitherto incurable conditions.

Pupil of Dr. Humphreys

McDowell's preceptor was Dr. Alexander Humphreys of Staunton, Va., a graduate of the University of Edinburgh. From the little that is known of Doctor Humphreys, he must have been an exceptional man. Certainly he was an anatomist, because there are several records of brushes with the authorities about the unlawful procurement of anatomical material. In addition to McDowell, he had two other celebrated pupils; one was Samuel Brown, who accompanied McDowell to Edinburgh, and the other was Jesse Bennett, who practiced in the vicinity of Staunton. On January 14, 1794, Mrs. Bennett went into labor and things went badly. Humphreys was called in consultation. Forceps were tried and failed. The choice of craniotomy or Caesarian section confronted the two doctors. Humphreys was for craniotomy. Caesarian section was then the most formidable procedure and neither had had any experience with it.

However, Bennett knew the horrors of craniotomy and, in desperation, chose Caesarian section. Assisted only by two Negro women, he laid open his wife's abdomen with one bold stroke of the knife and quickly delivered the child and the placenta. He then happened to glance at the ovaries, and as one witness declared, "He spayed her, remarking as he did so, 'This shall be the last one.'"

McDowell and Brown were not with Humphreys at this time, having gone to Edinburgh, arriving there early in 1793. In Edinburgh, John Bell dominated the scene. He was brilliant, eloquent, charming and dynamic and was the leading surgeon in Edinburgh. Following the examples of the Hunters in London, he had set himself up as an extramural teacher.

McDowell was greatly impressed by Bell who inspired him by his lectures and by his approach to surgical problems. When it came to diseases of the ovaries and the tragic consequences of the growths of ovarian cysts, he was especially eloquent.

It is certain that McDowell received much from Bell and it is doubtful if there was a greater surgeon in the world of that day than Bell. McDowell, therefore, came in contact with surgery at its best and was as well trained and well grounded as possible for his day and time. Those Americans who were with him at Edinburgh also felt this influence and they had much to do with the establishment of our present system of medical education.

On his return to America, McDowell immediately established himself in Danville and in a short while became the greatest surgeon west of the Alleghenies. Following his teachings, he continued his interest in anatomy and was accustomed to dissecting with his students more or less continuously. His reputation expanded and in 1804 the Philadelphia Academy of Medicine awarded him its honorary diploma.

The Crawford Operation

In 1809, he received a call to attend a Mrs. Crawford in Green County, Kentucky. She was supposed to be pregnant but was far past her time. On examination, he found the uterus to be normal and a tumor mass to be arising from the ovary. He informed Mrs. Crawford of his findings and of their significance and then proposed that she submit to an experiment in which he would attempt to remove the tumor. He told her quite frankly that such an operation had never before been successfully performed. She agreed, came to Danville, had the operation and, at the operation's conclusion, it is alleged that Dr. McDowell administered two stout shots of cherry bounce and re-enforced this medication by a couple of sympathetic pats. While I do not vouch for this, my own experience indicates that a well-placed pat has great therapeutic value, and that cherry bounce is a splendid restorative for the surgeon as well as the patient.

At this point, it is gratifying to mention that posterity has taken due note of the ailing Mrs. Crawford's heroic role and has honored her accordingly.

In the perspective of surgical history, this operation was the greatest single advance up until that time. In doing it, McDowell opened wide the door to abdominal surgery. With the advent of anesthesia and the aseptic technique, the surgery of the abdomen came into its own. It has been of life-saving benefit to countless millions of suffering individuals and reached such a high state of perfection that it demonstrated the possibilities of surgery in other regions. We are now beginning to see the fruits of these later advances in the brain, the lungs, the heart and the great vessels.

Possibilities of Surgery Untouched

What the future holds, no man knows, but it is certain that possibilities of surgery are as yet untouched. I think it safe to say that the scientific advances in the realm of medicine, surgery and pharmalology are the outstanding contributions of our present-day civilization.

These advances have created a new problem—that of old age—and it is not unlikely that the centenarian will be commonplace in the near future. With the development of arterial transplantation, it

is now possible to replace the worn-out arteries of an individual with those of persons who have died of accidents. The surgery of cancer has begun to make inroads on the mortality from that dread disease. In Doctor McDowell's day, cancer of the uterus was 100 per cent fatal disease. Today, the cure rate is approaching 50 per cent and if the present available knowledge were fully utilized and the cooperation of every women could be secured, the cure rate could rise to 100 per cent in the next ten years.

The possibilities for the future indicate that the cause of cancer will be found, that the aging process will be retarded, and that organs may be transplanted from one individual to another. The economic and social consequences of these developments will be the great political and sociological issues of tomorrow.

Beginning of Abdominal Surgery

McDowell, by his operation on Mrs. Crawford, inaugurated the new era in surgery. This was the beginning of abdominal surgery. Because of this, he deserves to be ranked in the forefront of the benefactors of mankind and is therefore entitled to great and lasting fame. There are many kinds of fame, most of which are short-lived, often of a doubtful or questionable nature. True and permanent fame results only from a contribution to the happiness of humanity.

It is doubtful, however, if such fame as that a grateful humanity bestows in recognition and gratitude for a past contribution is of much value in influencing subsequent contributions. A notable exception is in the case of those great men whose spirits survive in the minds and hearts of those who follow. The Kentucky State Medical Association, no doubt, had this in mind when it caused Doctor McDowell's memorial to be engraved with the phrase: "A grateful profession reveres his memory and cherishes his example."

The Surgeon's Ideal

In studying McDowell, surgeons find their ideal. He had all those qualities which we surgeons find admirable and worthy of emulation. His courage has sustained the faint heart of many a successor. His ability to face up to responsibility has stimulated the decision of many a wavering surgeon. His ability to take criticism and abuse and not be disheartened and discouraged or bitter has shown many of us the way in which things should be taken. He regarded surgeons as ministering angels whose duty it was to relieve suffering and glorify God. Intensely conscientious and with a scrupulous regard for the welfare of his patients, he was generous to a fault in dealing with them, and none grieved his death more than the poor of Danville.

Surgeons yet unborn will strengthen their determination and refresh their courage in the river of his glory. He endowed surgery with a great tradition. May God make his successors ever worthy of his great example.

SPECIAL ARTICLE

The Place of Drugs

(Continued from Page 62)

still longer before instruction began at that fascinating and nationally unique institution, the Louisville College of Pharmacy for Women (1892).

Learned Lore As Apprentice

The road to the skills and lore of pharmacy in the settled parts of the United States usually was found during a medical apprenticeship, when a neophyte would gather herbs, pound up drugs in a big contusion mortar, fill bottles, and similarly keep himself out of mischief when not accompanying his preceptor on his medical rounds through the countryside.

These duties, plus booklearning self-gained from one of the British dispensatories, no doubt occupied many of the hours of young Ephraim after he apprenticed to Dr. Alexander Humphreys at Staunton, Va., in 1790.

Under the influence of his preceptor, young Ephraim later went abroad to the University of Edinburgh. This famous medical center had produced a pharmacopeia renowned internationally for its high level and progressive bent.

Never Earned Medical Degree

Like most American practitioners of his time, McDowell could not sit in class long enough to earn a medical degree. Even so, a biographer, James Flexner, considered him "the best-trained surgeon beyond the (Allegheny) mountains," and we dare presume that some of Edinburgh's preoccupation with drug knowledge rubbed off on the young surgeon.

What, then, was his basic view on the role of drugs in medical care? According to Flexner, "he told his private pupils that a sick man left to Nature's healing care would do better than one so dosed and harried" by the heavy prescribing of drug concoctions then fashionable. That suggests a certain antipathy between the apothecary shop, which represents for us one side of McDowell's career, and his conservative attitude toward the drug therapy then practiced.

Even a pharmacist may admire, rather than decry, McDowell's sceptical attitude toward medication when we recall the ambiguous position of drug therapy at the beginning of the 19th Century.

Daring Ideas of Paracelsists

The revolution in the physical sciences, combined with the impact of such medical iconoclasts as the Paracelsists, had pushed into disuse the old Galenic dogma, with its rational but quite wrong concept of drugs counteracting the excess of the four basic humours, or juices, in the body. Followers of Paracelsus introduced daring ideas of the internal use of chemicals and of the healing quintessence hidden in many of nature's products; yet they had no conceptual structure for their ideas of therapy that could be experimentally confirmed. The field of medicine and

the living body were too complex to apply successfully the methods and concepts that had reshaped the physical sciences.

It often has been said that a merit of Paracelsus was that he opened the window of medical minds to new ideas and left them open—not closing them off in another theoretic dogma. While this seems true, others less hesitant made the 18th Century a welter of conflicting or variant theories about the nature of disease and its proper treatment.

Some of these were brilliant intellectually, quite the equal of our best thought today. Our reservations lie more in the direction that they had little relation to the actual etiology of illness and action of drugs, as we understand these sciences. A simple explanation lies in the fact that not even the foundation for modern microbiology and pharmacology had been laid. Quantifiable or reproducible tests of drugs were still too primitive and occasional either to reshape or limit drug therapy within a commonly-agreed-upon system of practice or set of criteria.

Heroic School of Drug Prescribing

The Edinburgh authority, William Cullen, and two of his students, the American Benjamin Rush and the Briton John Brown, especially fostered a heroic school of drug prescribing, as we meet it in the world of Ephraim McDowell. Their beautifully consistent and complete system of therapy regarded life as non-existent except as a result of the action of outside stimuli upon an organized body of tissues. The body, therefore, was in a state of disease according to whether the vital tone or "excitement" of its tissues had increased or diminished from normal. Drastic treatment was needed often, either to stimulate or depress a particular type or location of "excitement." The Frenchman, F.-J.-V. Broussais, modified the theory of Brown, without lessening the rigors it meant for the patient.

Early in the 19th Century the average American physician, interpreting what he observed in the light of such theory and its variants, felt it his duty to provide massive doses of calomel and copious blood letting.

In his thought McDowell seems to have been more an heir of Hermann Boerhaave, the Dutch clinician, whose far-greater confidence in the healing power of nature, down-to-earth empiricism, and conservative treatment reminds us so much of the Hippocratic tradition.

The sceptics of McDowell's own time were most vocal in the Paris clinical school, climaxed later by the drug nihilism centered at Vienna and, in a less intellectual but more violent way, in criticisms by the Thomsonian sect in the United States.

The End of An Era

McDowell thus stood at the end of an era in drug therapy. Many hopelessly outmoded drugs had been cleaned from the shelves of pharmacies. Ossified traditions in the use of drugs had broken down. Botanical exploration and chemical discovery were adding new medications. Yet, only a few drugs known —such as cinchona—had a specific action against the course of specific diseases. Little that was helpful had yet been learned about the amount or character of the active constituents contained in crude drugs drawn from nature.

It is revealing that only four years before McDowell's first ovariotomy the German pharmacist, Friedrich Serturner, reported discovery of morphine in opium; and his understanding of its alkaloidal character opened a whole new field of medicinal chemistry. In the immediate years ahead, other leading pharmacists of Europe would separate and identify active constituents of drugs, such as the quinine in cinchona bark. This trend toward well-defined and measurable drugs would have been important, but hardly revolutionary, if it had not accompanied, and helped make possible, a modern understanding of the action of these powerful substances upon living tissues.

How telling the coincidence that Francois Magendie came to the fore as an experimental physiologist just at the time when McDowell was performing his first ovariotomies. Calling Magendie the "father of experimental pharmacology," Professor Ackerknecht, the medical historian at Zurich, points out that the French physician and his student, Claude Bernard, experimented with newly-isolated alkaloids, glucosides, and elements that "for the first time permitted an exact experimental procedure." He rightly states that attempts to experiment with drugs (contrasted with merely observing their supposed effect in practice) were by no means new. Yet, it was new and crucial that, gradually, "the greater chemical knowledge of drugs and the greater physiologic insight into the organism" permitted systematic, experimental study of the effect of drugs on organs and organ-systems.

Seeds Sown, Partly Sprouted

If we now take stock from our vantage point of 1959, much of what has seemed so miraculous as a culmination of 150 years of progress in drug therapy seems a logical outgrowth of seeds sown and partly sprouted already in McDowell's time. Yet, there were discoveries along the way of such basic importance, even if not conceptually fundamental, that the practice of medicine and pharmacy and the pursuit and expectation of human life itself have been utterly transformed.

The diversity and drama of these discoveries may appear as scintillating and haphazard as a fireworks display. Yet, perhaps the basic achievement—that would rival in importance the emergence of pharmacologic checks and tests of drug action—still can be reduced conceptually to a single line of development.

I refer to the idea and realization of drugs that have a specific action against specific disease-causing agents, without doing unbearable harm to the cells or body carrying the disease.

Insofar as this idea involves chemical drugs we refer to it as chemotherapy. But the excitement of its first reality had animal rather than chemical

origins when serum therapy was introduced in 1893 by Emil von Behring, whose work was bound up with discoveries by contemporary workers, such as Robert Koch and Paul Ehrlich, to mention only two of the more famous ones. Neither the idea not even the realization of specific therapy was by any means new. Why, then, did this event have such far-reaching significance? As Professor Ackerknecht has pointed out, the tetanus and diphtheria antitoxins represented fulfillment of "the old dream of specific and etiologic agents, *not due to chance but to systematic research.*" On this basis we have become heir to an unbroken succession of drugs with specific action since discovered.

Other Notable Groups

Like the antitoxins, sera, and vaccines, other important classes of drugs, unknown in McDowell's time, have been wrested from the world of natural products. Vitamins and hormones are two notable groups in which there have been vital advances with each passing decade.

Occupying a still larger segment of today's pharmaceutical resources, which the physician may draw upon, are the organic medicinal chemicals. Some of the early synthetic products made before 1890 still find medical use today, such as chloral (1832), salicylic acid (practical 1874), and antipyrine (1884). Yet, these had only symptomatic effect; the rising tide of organic chemicals with specific therapeutic effect pouring from laboratories traces back more properly to arsphenamine (dubbed "606") as a specific against syphilis. Next year it will be just a half century since Paul Ehrlich, aided by S. Hata, laid this cornestone of today's chemotherapy.

Advent of Antibiotics

The advent of antibiotics after the 1930's—in its fundamentals, a British development—turned attention back once again to the resources and the resourcefulness of nature. It might be contended that the tremendous advance represented by this class of drugs introduces no basically-different concept or approach into drug therapy. Yet, practitioners in the health field and laymen alike are keenly aware in 1959 that our life chances are greatly strengthened and the total cost of many afflictions greatly lessened by antibiotics, whose revolutionary effect on clinical medicine is still unfolding.

The intervening period between 1809 and 1959 has approximately doubled the life expectancy of each one of us, at birth. We are forced to conclude that a major but immeasurable share of this gain lies in the changing effectiveness of drugs in the practice of medicine, rather than in the extent of use. The rate of innovation in the pharmaceutical field has increased, perhaps tenfold, during this period. And since Ephraim McDowell struggled against disease, in a Kentucky then still somewhat a wilderness, the whole conceptual basis and outlook of pharmaceutical research and drug therapy have changed.

Advances a Product of Teamwork

This change by no means has been wrought by pharmacy alone or any other single specialty. On the contrary, advances have been increasingly a product of teamwork among medicine, pharmacy and the sciences basic to them, and whole new fields of scientific work that therapeutic advances have called into being. Even within the field of pharmacy itself—in the research institute, the manufacturing laboratory, the corner pharmacy, and its counterpart in the hospital—these advances have both stimulated, and been stimulated by, higher specialization, advanced education, and new approaches to pharmaceutical problems and services—by a profession that, on American soil, did not even exist in McDowell's time.

Mrs. Crawford lay here on a table, sobbing and singing hymns, under McDowell's knife without benefit of antisepsis or of anesthesia beyond heavy doses of opium. It reminds us on this historic site how far drug therapy and the professional knowledge behind it have progressed since that daring feat of surgery.

Bibliographic Note

Historical information in this address has been drawn largely from Erwin H. Ackerknecht, "Wendepunkte in der Geschichte der Pharmakotherapie," Schweizerische Apotheker-Zeitung, 95 (1957), 751-757; Jul. Petersen, "Happtmomente in der geschichtlichen Entwickelung der medicinischen Therapie," Kopenhagen, 1877, 400 pp.; Carl A. Dragstedt, "An Historical Consideration of Pharmacology," Quarterly Bulletin (Northwestern University Medical School), 32 (1958), 179-186; W. D. M. Paton, "The Impact of Pharmacology on Medicine," The Medical Press, 5 September 1956, pp. 213-217; Antibiotics Number of the Journal of the History of Medicine and Allied Sciences, 6 (1951), No. 3; C. L. Lautenschlager, "50 Jahre Arzneimittel-Forschung," Stuttgart, 1955, 486 pp.; "A Backwoods Galahad; Ephraim McDowell" in James T. Flexner, "Doctors on Horseback," New York, 1937, pp. 121-164.



Do You Deserve a Tribute?

IN Robert Louis Stevenson's "A Tribute to the Doctor" there is the following line. "He (the physician) is the flower of our civilization and when that stage of man is done with and only remembered to be marveled at in history, he will be thought to have shared as little as any in the defects of the period and most notably exhibited the virtues of the race."

Robert Louis Stevenson would hardly recognize the majority of the physicians of the 20th Century. For almost 30 years we, the physicians, have failed to show "the virtues of the period" and have "let the Georges do it" until we have possibly contributed "to the defects of the period."

We have been "brain-washed" into believing that our one duty in life is to have our patient's health in our mind and let the "Georges" take care of government and our way of life. "Historians of the future will marvel most of all at the non-resistance of those who had the most to lose." When the nation began there were six physicians who signed the original Declaration of Independence. The six were imbued with the idea of personal freedom. They were educated men. They were trained in the classics. They were men who accepted their responsibilities as citizens in the success or failure of the new republic.

We modern physicians are going to be rather cruelly and harshly delt with by the historians of the future. Sometimes, we allow men to be elected to political offices who are moral and mental midgets and see the last wedge driven into the tree to split the patient and physician relationship.

The year of 1960 may well be the year of our time when physicians can regain the accolade in "A Tribute to the Doctor."

In 1960 there will be elected a President, a Vice President, 33 Senators, 400 members of the House of Representatives, 27 Governors and innumerable other state, county, city and town officials. The labor unions are at work in Washington, in Frankfort and in your local precinct.

Edmund Burke said, "The true danger is when liberty is nibbled away for expedience and by parts." Every elected official may contribute to the nibbling or be aided by the informed, interested, conscientious, true, citizen-physician. The physician should be interested enough to aid in the selection of the candidate and then to support him or her by his voice, his pen, his money and last, but never least, the daily prayer to keep his character in the face of the socialist-communistic pressures of the modern Ghengis Khans who are attempting to sack our civilization.

PHYSICIANS OF 1960, WHAT WILL WE DO? "EXHIBIT THE VIRTUES" OR "SHARE IN THE DEFECTS?"

Wyatt N. Norvell, M.D.
Chairman for State Affairs
KSMA Legislative Committee

High Fidelity

THE Kentucky State Association of Registered Nurses News Letter under date of November, 1959, carries the following resolution which was adopted by this Association at its 53rd Annual Meeting in Louisville September 23rd to 25th:

BECAUSE nurses recognize that the nursing profession and employers of nurses share responsibility for provision of adequate nursing service to the public, be it

RESOLVED that professional nurses voluntarily relinquish the exercise of the right to strike and of the use of any other measures wherever they may be inconsistent with the professional nurses' responsibilities to patients, and

FURTHER RESOLVED that this voluntary relinquishment of measures ordinarily available to employees in their efforts to improve working conditions, imposes on employers an increased obligation to recognize and deal justly with nurses in all matters affecting their employment conditions.

We cannot commend too highly the spirit which motivated the passage of this resolution. It is encouraging and heartening to our profession that our sister organization maintains so high a standard of professional conduct.

Sam A. Overstreet, M.D.

We Endorse

SOMETIME ago there came to our hands a brochure entitled "An Agricultural Science Center for Kentucky" describing outlines for a rather ambitious step toward agricultural development in our State.

We as physicians tend to become absorbed in the projects which are nearest to us and for which we personally feel directly responsible. We tend to forget that other programs quite as important in the development of our State deserve our endorsement and support. The project under discussion is one of these.

Mr. Ernest Harris, an Oldham County farmer and a leader in the Kentucky Farm Bureau Federation, states, "Farming may be declining in numbers, but its importance is as great as it ever was, in fact it may be more important. . . . Half the people in the state of Kentucky are either farmers or directly concerned with farming."

There is proposed a $10,000,000 Agricultural Science Center for the University of Kentucky's College of Agriculture and Home Economics at Lexington as a "keystone" to a widespread program for improvement of agriculture in our State.

Agriculture, just as medical care, and many other basic enterprises in our State can be improved. We endorse all intelligent and well-planned efforts toward this end.

Sam A. Overstreet, M.D.

ORGANIZATION SECTION

Officers Conference March 31 To Hear Dr. Alford

Dale Alford, M.D., Congressman from Little Rock, Ark., will be the featured speaker at the 10th Annual County Society Officers Conference in Owensboro on March 31.

Irvin Abell, M.D., Louisville, KSMA president, said the conference will be held at Gabe's, spacious new restaurant at 18th and Triplett Streets.

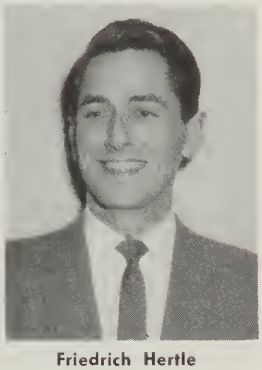
F. L. Feierabend, M.D., president of the Committee on Plans of the National Blue Shield Commission, will be among the top speakers at the morning session. Doctor Feierabend, who makes a dynamic presentation, will speak on "Quo Vadis."

A feature of the afternoon will be a stimulated hearing before the House Ways and Means Committee on legislation affecting hospital and medical care. Top AMA officials, Doctor Abell said, will participate in this important session.

The complete program for the conference will be published in the February issue of The Journal.

Postgraduate Medical Fund Director Appointed

Appointment of Friedrich Hertle, Ph.D., native of Munich, Germany, as executive director of the new Postgraduate Medical Fund office, just opened on the University of Louisville campus, has been announced by Walter S. Coe, M.D., Louisville, chairman of the KSMA Associate Committee on Postgraduate Education.



Friedrich Hertle

Mr. Hertle, who is 31 years old, first came to the United States in 1952 under an exchange-student program. Returning to Europe to complete his education, he was graduated from the University of Basle in Switzerland in 1958 with a Ph.D. degree in economics and business administration. He is married to a physician, Hildegarde Hertle, M.D., who specializes in anesthesiology and is a member of the staff at St. Joseph Infirmary.

Doctor Coe also announced the schools in seven adjoining states whose postgraduate opportunities will be listed in the KSMA Journal and Secretary's Letter, starting in March. Schools to be covered include Vanderbilt University, University of Tennessee, University of Cincinnati, University of West Virginia, Indiana University, Washington University and Ohio State University.

Tranquilizers Is KAGP Subject For Seminar Jan. 21

Eight scientific papers covering the general subject, "Tranquilizers—Their Clinical Application," will be presented at the Northern Kentucky Seminar of the Kentucky Academy of General Practice at the Sheraton Gibson Hotel in Cincinnati on Thursday, January 21. The program has been submitted for four hours of Category I credit.

Physicians from seven states will conduct the scientific sessions. William K. Willard, M.D., dean of the University of Kentucky Medical Center, will be the luncheon speaker. More than 100 are expected to attend the Seminar.

The scientific program, starting at 10 A.M., has been announced as follows:

Pharmacology Of Tranquilizer—G. J. Martin, M.D., Lakeland, N. J.

Tranquilizers In Geriatrics—Edward H. Hashinger, M.D., LaJolla, Calif.

Tranquilizers—F. Bambace, M.D., San Antonio, Texas

Tranquilizers In Surgery—Neal Owens, M.D., New Orleans.

Tranquilizers In Obstetrics—Walter Reich, M.D., Chicago.

A New More Potent Neuroleptic Agent—E. S. McCabe, M.D., Philadelphia.

Tranquilizers In Internal Medicine—Walter S. Coe, M.D., Louisville.

Tranquilizers In Psychiatry—Harry H. Wagenheim, M.D., Philadelphia.

Dr. Bosworth Reappointed

N. L. Bosworth, M.D., Lexington, was reappointed to a three-year term as the KSMA member of the State Advisory Committee of the Practical Nurse Training Program of Kentucky by Superintendent of Public Instruction Robert R. Martin on December 3. Dr. Martin was appointed Commissioner of Finance by the new administration which went into office on December 8.

The Practical Nurse Training Program is carried on by the Division of Vocational Education, under the State Department of Education.



This map shows the boundaries of the various congressional districts

This Listing Will Help You Keep In Close Touch With Kentucky's Lawmakers In Washington

You will want to let your Congressmen and Senators know how you feel on various issues relating to the health and welfare of the people and medical profession of Kentucky, to be considered in the Second Session of the 86th Congress which convened last week, says George P. Archer, M.D., Prestonsburg, co-chairman of the KSMA Legislative Committee for National Affairs.

Full information on how to contact each Senator and Congressman from Kentucky is listed below. Doctor Archer says his committee urges all members of KSMA to be in frequent touch with their lawmakers.

U. S. SENATORS

Name	Home Address	Capital Address	Telephone
John Sherman Cooper (R)	Somerset	Room 110, Senate Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 2542
Thurston B. Morton (R)	Glenview	Room 259, Senate Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 4343

U. S. REPRESENTATIVES

	Name	Home Address	Capital Address	Telephone
1	Frank A. Stubblefield (D)	Murray	Room 1228, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 3115
2	William H. Natcher (D)	Bowling Green	Room 117, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 3501
3	Frank W. Burke (D)	Louisville	Room 220, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 5406
4	Frank L. Chelf (D)	Lebanon	Room 449, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 3465
5	Brent Spence (D)	Fort Thomas	Room 1129, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 2305
6	John C. Watts (D)	Nicholasville	Room 1534, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 4706
7	Carl D. Perkins (D)	Hindman	Room 1409, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 4935
8	Eugene E. Siler (R)	Williamsburg	Room 209, House Office Bldg. Washington, D. C.	Capitol 4-3121 Extension 4601

AMA Washington Office—1523 L Street, N. W., Washington, D. C. Sterling 3-8155
Manager—Roy Lester, M.D.; Legislative Representative—Mr. Cecil Dickson

Dr. Orr Charges Physicians To Larger Civic Role

Physicians *must* take a more active interest in the whole area of politics, public affairs and community life, AMA President Louis M. Orr, M.D., Orlando, Fla., told the nation's doctors attending the 13th Clinical Meeting of the American Medical Association in Dallas, December 1-4.

"Politics is not an activity that should be entrusted to the venal or the second rate," he said in pleading for the physicians to play a larger role in this area.

Doctor Orr also emphasized the importance of telling medicine's positive story at every opportunity. "Are you helping to break down the myth that the American Medical Association and the medical profession always are against something, never for anything?" he asked.

The whole story—not only with respect to legislation but also to the profession's positive programs on aging, chronic illness, care of the indigent, medical school expansion, relations with third parties and many other areas—must be told more effectively, and then told and retold again, he said.

The president charged the members of the House of Delegates with two specific duties: (1) to do everything within their power and influence to see that the orientation program on the Forand Bill is carried out vigorously on both the state and county levels; (2) to see that their state and county societies are carrying out a vigorous, imaginative program with respect to aging and health care of the aged.

Hickman First With 1960 Dues

Hickman County was the first to pay KSMA and AMA membership dues for 1960. A check from H. E. Titsworth, M.D., of Clinton, Hickman County Medical Society secretary, was ahead of all others received in the KSMA Office.

1,235 Apply For Blue Plan For the Elderly

A special Blue Cross-Blue Shield plan for eligible persons age 65 or over was offered to Kentuckians from November 15 to 28, 1959. By December 11, a total of 1,235 applications and 2,876 inquiries had been received in the Blue Cross-Blue Shield office.

Persons eligible were Kentuckians 65 or older, in good health, who were unemployed or otherwise not eligible for group membership. Annual income should not exceed $1,500 for single persons or $2,500 for man and wife; resourses, $15,000 for single persons and $25,000 for family.

Applications are being underwritten, and there will be a 12-month waiting period for any conditions determined to be pre-existing.

Blue Shield benefits are: Allowances for surgery and anesthesia and radiation therapy will be according to a schedule of indemnity. Payments to the doctor for in-hospital medical treatment or non-surgical cases will also be made, plus a diagnostic x-ray schedule if provided in a hospital, in a hospital out-patient department, or in a doctor's office if hospitalization follows immediately. Blue Cross will provide in full certain hospital services and $5 per day for room allowance.

The boards of trustees of Kentucky Physicians Mutual and Blue Cross have announced that they have no plans for repeating the special offer.

Seminar On Trauma Set Jan. 27 At Fort Campbell

The Kentucky Committee on Trauma will present its first seminar for 1960 on January 27 at the U. S. Army Hospital in Fort Campbell, at the invitation of Col. R. J. Kamish, according to announcement by William T. Rumage, Jr., M.D., Louisville, chairman for Kentucky. Physicians from neighboring communities in Kentucky and Tennessee will be invited to attend.

The program will be devoted to the diagnosis and treatment of various injuries anticipated as a result of serious automoible accidents. Speakers and the subjects of their papers will include: Ludwig H. Segerberg, M.D., Louisville, "Head Injuries and the Use of Hypothermia"; F. Albert Olash, M.D., Louisville, "Cardiac Contusions and ECG Changes"; Robert Lich, Jr., M.D., Louisville, "Vesical Urethral Injuries," co-authored by Lonnie W. Howerton, Jr., M.D., Louisville; R. Arnold Griswold, M.D., Louisville, "The Significance of Reporting Automobile Accidents and Mortality Rates."

The Kentucky Committee is composed of practitioners from all fields who are concerned with the prevention, diagnosis and treatment of accidental injuries.

16 Kentucky M.D.'s Attend AMA Meeting In Dallas

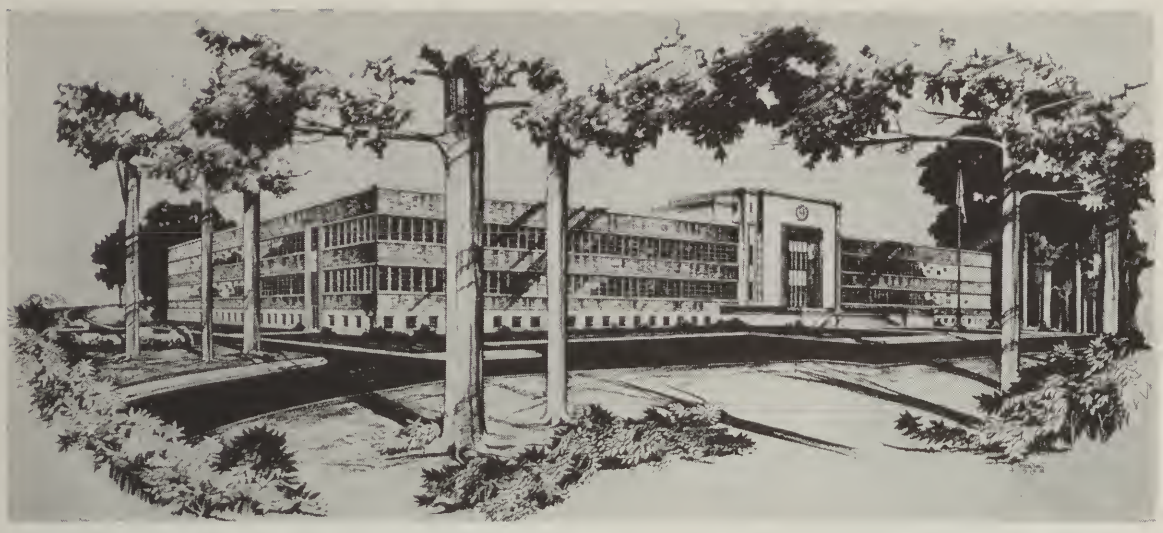
Sixteen Kentucky physicians attended the American Medical Association's 13th Clinical Meeting in Dallas, December 1-4, according to registration figures published in the AMA Daily Bulletin.

W. Vinson Pierce, M.D., Covington, and Robert C. Long, M.D., Louisville, KSMA delegates to the AMA, served in the House of Delegates. George P. Archer, M.D., Prestonsburg, attended as alternate delegate and J. Vernon Pace, M.D., Paducah, served on behalf on Foster D. Coleman, M.D., Louisville. (Doctor Pace succeeded Doctor Coleman as alternate delegate to the AMA on January 1.)

Other Kentuckians listed in the AMA Daily Bulletin were:

December 2—T. H. Biggs, M.D., London; R. H. Cofield, M.D., Covington; M. R. Cronen, M.D., Louisville; Horace Harrison, M.D., Owensboro; P. L. McShane, M.D., McDowell; Owen B. Murphy, M.D., Lexington; Thomas G. Perkins, M.D., Paris; John O. Shaw, M.D., Hazard; Thomas G. Stigall, M.D., Louisville, and Thomas J. Vecchio, M.D., Middlesboro.

December 3—David G. McClure, M.D., and Carroll L. Witten, M.D., Louisville.



Architect's sketch of Kentucky's new $2,750,000 Health Building in Frankfort shows how the structure will look when it is completed in mid-February. The building, dedicated Dec. 6, is located on east grounds of Kentucky Training Home.

New Health Building In Frankfort Dedicated Dec. 6

The State Department of Health's new home in Frankfort—the McCormack Memorial Health Building—was dedicated on December 6.

(After the inauguration of the new administration, strong efforts were made to keep the Department in Louisville. However, on December 18, Governor Combs announced that the building had gone beyond the point of no return and that the Department would be moved as scheduled).

The ceremony honored a father and son whose combined services as Kentucky's first two health commissioners covered 64 years. They were Dr. Joseph N. McCormack, who became the state's first health commissioner in 1878 and served until 1912, and Dr. Arthur T. McCormack, who succeeded his father and was in office until his death in 1943.

Governor A. B. Chandler was the speaker at the dedication. Russell E. Teague, M.D., present Commissioner of Health, presided. Others on the program included H. F. McPheeters, M.D., Commissioner of Mental Health, and E. M. Howard, M.D., Harlan, president of the State Board of Health.

The new building, scheduled for completion in mid-February, was built at a cost of $2,750,000. It is so designed that two more floors can be added and is expected to cost $4,000,000 when completed.

AAGP Assembly Set March 21-24 In Philadelphia

The American Academy of General Practice has scheduled its 12th Annual Scientific Assembly for March 21-24 in Philadelphia's Convention Hall. The Assembly this year is combined with the Philadelphia Postgraduate Institute.

The advance program lists 31 prominent medical educators who will discuss a variety of subjects ranging from arthritis and anemia to surgery, geriatrics and mental health. More than 100 scientific and 300 technical exhibits are booked. Physical examination sessions, during which more than 600 doctors had checkups at the last meeting, will be a feature again this year.

The Academy, which has more than 26,000 family doctor members, is expecting an attendance of more than 4,000.

59 Blue Shield Programs for Aged In the Works, Survey Shows

Only eight of the 67 Blue Shield Plans located in the United States—with only 2 per cent of the total Blue Shield membership—have no programs for senior citizens in the works at the present time, a survey completed in December reveals.

The remaining 59 Plans, including Kentucky, either have special aged programs already being offered in their areas or have programs in various stages of development, announced John W. Castellucci, Chicago, executive vice-president of the National Association of Blue Shield Plans. Kentucky's Plan was announced in the November issue of The Journal.

The survey was made to determine the progress the Blue Shield Plans and their sponsoring medical societies have registered in implementing the AMA resolution—passed December 4, 1958—calling for the development of medical care coverage for the aged by voluntary means.

"The results are most encouraging," said Mr. Castellucci.

CNS Elects Dr. Marshall

Thomas M. Marshall, M.D., Louisville, was elected president of the Congress of Neurological Surgeons at the organization's annual meeting in Miami Beach. Doctor Marshall served as vice-president last year and has held other offices in the Congress.

New I.R.S. Ruling Provides Check On Medicare Funds

Under a new ruling, Blue Plans that disburse Medicare Funds on behalf of state medical societies must file special returns with the U. S. Internal Revenue Service. These returns will list the name, address and amount paid to each doctor who gets more than $600 a year.

The U. S. Treasury Department will then match this return with the taxpayer's return and, upon examination, a careful check will be made to determine if the amount is reported as income.

This special return (Form 1099) is usually required to be filed with the Federal Government in any case involving payments in excess of $600, and where there is no withholding of income taxes.

Dr. Scott Named Councilor For 10th District

Douglas E. Scott, M.D., Lexington, is the new Councilor for the 10th Councilor District, which is composed of Fayette, Jessamine and Woodford Counties.

Richard G. Elliott, M.D., Lexington, who was elected as the Councilor at the 1958 Annual Meeting to serve a three-year term, was elevated to the office of President-Elect of KSMA at the 1959 meeting of the House, thus creating a vacancy on the Council.

According to Chapter VII, Section 9, of the KSMA Bylaws, when there is a vacancy the delegates from the counties of a councilor district may nominate someone from their district as a replacement. The Council may then elect the nominee to serve out the association year, after which the House of Delegates may fill the office for the remainder of the term.

80 Kentuckians Registered At SMA Meeting

Kentucky was represented by 80 physicians at the 53rd annual meeting of the Southern Medical Association in Atlanta, November 16-19.

The registration list, announced by Robert F. Butts, Birmingham, associate executive secretary and treasurer, included the following Kentucky M.D.'s:

Louisville—Irving B. Perlstein, Phillip D. Briggs, J. Duffy Hancock, William Ray Moore, Eugene H. Kremer, Jr., A. Clayton McCarty, Richard R. Slucher, Hugh S. Thompson, Jr., Avrom M. Isaacs, Henry G. Saam, Art J. Shulthise, Sam A. Overstreet, Raleigh E. Witten, Carroll L. Witten, John D. Gordinier, Oscar O. Miller, R. F. Radmacher, Ralph M. Denham, William P. Vonder Haar, Marvin A. Lucas, Augustus J. Pauli, Isadore Goldstein, Paul S. Osborne, R. O. Joplin, J. B. Marshall, James E. Skaggs, George S. Allen, Glenn W. Bryant, Silas H. Starr, John D. Allen, Marjorie Rowntree, Gradie R. Rowntree, Eugene H. Conner and Thomas J. Crice.

Lexington — Howard E. Dorton, O. T. Evans, George Gumbert, Jr., W. E. Herrell, Maurice Kaufmann, Joseph B. Parker, Jr., and Douglas E. Scott.

Bowling Green—Jess Funk, Guthrie Y. Graves and R. C. Moss.

Covington—Robert H. Cofield, C. M. Heisel and A. J. Schwertman.

Hopkinsville—Rachel C. Croft, James R. Dave, Norma T. Shepherd and Harvey B. Stone.

Ashland—Paul A. Bryan; Auburn—C. A. Wood; Barbourville—Harold L. Bushey; Bardstown—A. D. Steely; Calvert City—Carroll W. Traylor; Campbellsville—W. B. Atkinson and M. M. Hall; Dorton—Roy Sanders; Edmonton—E. S. Dunham; Elkton—Lewis R. Sutton; Fulton—David L. Jones; Glasgow—R. E. Hayes; Harlan—Henry Evans and Dwight M. Kuhns; Hazard—Charles C. Rutledge.

Jeffersontown—J. A. Bishop; Ludlow—Charles W. Justice, Jr.; Maysville—William M. Savage; Madisonville—Eugene H. Castle; Middlesboro—William L. Donham; Midway—Ben F. Roach; Middletown—Ansel V. Simon; Murray—A. D. Butterworth; Morgantown—D. G. Miller, Jr.; Paducah—Martin S. Kleckner, Jr.; Paris—M. B. Dillon; Russell—Charles B. Johnson; Stanford—Howard I. Frisbie; Williamsburg—R. D. Sanders.

AMA Clinical Session Draws 3,000 M.D.'s to Dallas

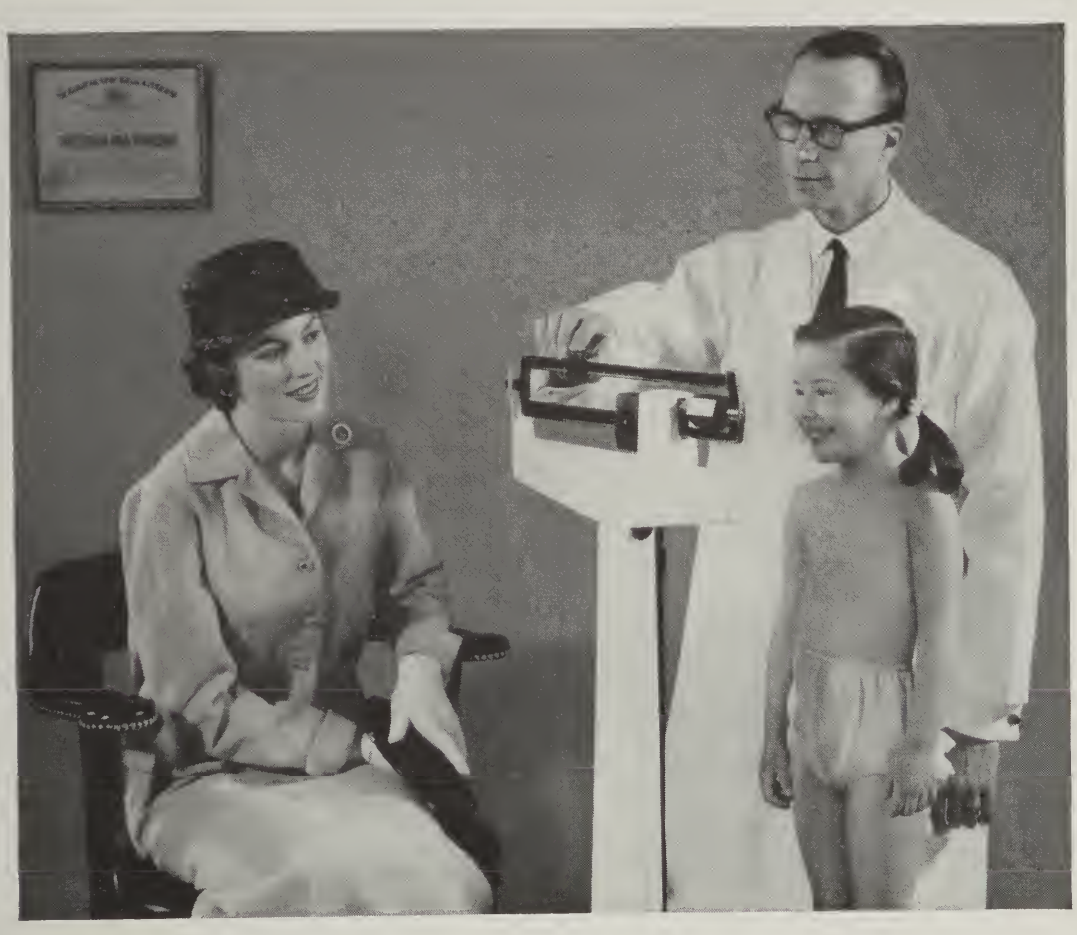
Approximately 3,000 physicians from all parts of the country attended the 13th Clinical Meeting of the American Medical Association held December 1-4 in Dallas.

A feature of the meeting was a one-day symposium on the effect of sunlight on skin. Physicians were told they should take the lead in educating the public on the adverse effects of sunlight.

A special report, "The Other Side of the Sun," originating from the Clinical Meeting, was televized to the Dallas-Fort Worth area. Based on information from the symposium, the program is one of the CBS-TV "Ask Your Doctor" series originated by Merck Sharpe & Dohme in connection with major medical meetings.

A trans-Atlantic conference between medical experts at the AMA meeting and representatives of the British Medical Association, meeting in Glasgow, Scotland, gave the Dallas session an international flavor on December 3. During an hour-long exchange, a panel from each medical group diagnosed a cardiopulmonary problem case presented by the opposing panel. The two-way audit contact was sponsored by Smith, Kline & French Laboratories.

New methods for the correction of heart-lung disease were demonstrated via closed-circuit television as one of seven programs presented at the Clinical Meeting by Smith, Kline & French. The other telecasts included clinical and surgical presentations on cancer chemotherapy, neurological difficulties of childhood, orthopedic problems, a Caesarean section with possible hysterectomy, common dermatological cases and ophthalmology.



Underweight Children Gain and Retain Weight with Nilevar®

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

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*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethondrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

"Mr. Sam" and Senator Johnson Address AMA House

Two hundred out of a possible 208 heard two distinguished Texans, Speaker of the U. S. House of Representatives Sam Rayburn and Senate Majority Leader Lyndon Johnson, address the opening meeting of the AMA House of Delegates at Dallas on December 1.

Mr. Rayburn urged the physicians to become acquainted with the issues in which they were interested and come to Washington themselves to let the House of Representatives know how they felt, rather than send someone to represent them. Mr. Rayburn stressed that physicians generally should take more interest in politics and pointed out that the representatives and senators who represented their constituency at home were no better than the people who elected them.

"Mr. Sam" felt the problem of obtaining more physicians for our growing population should be attacked as effectively as possible and solved at the earliest possible date.

Senator Johnson told his audience that men who control space will control the weather, and whoever controls the weather will control the world. He felt at present this country was not in first place.

Senator Johnson urged that our nation become imbued with three essentials to world leadership: (1) strength, (2) purpose, and (3) determination. The latter, he felt, was most important. This country, he said, "has two choices, it either must lead or be led."

Diabetes Group Hears Dr. Morse

Carlisle Morse, M.D., Louisville, Governor for Kentucky for the American Diabetes Association, made the featured address before the Greater Kansas City Diabetes Group in November. About 400 were present.

Eldon Miller, M.D., Kansas City, Kan., ADA's Governor for Kansas, presided at the meeting and introduced Doctor Morse. The Greater Kansas City Group covers Kansas City, Mo., and Kansas City, Kan.

$1,000,000 Doctors' Building Planned For Louisville

Medical Towers, a $1,000,000 medical-office building, is proposed as the latest addition to the Louisville Medical Center. Early 1961 is set as the occupancy date.

Plans to build an eight-story structure on the northwest corner of Floyd and Gray Streets have been announced by V. V. Cooke, automobile dealer. The building will be of reinforced concrete with a facade of horizontal bands of windows, and metal panels below each window.

The first six floors will be occupied by doctors' offices and the top two floors will contain apartments for Medical Center residents. The ground floor will have an apothecary shop and allied conveniences.

Pictured on the opposite page are scenes from the Ephraim McDowell Stamp celebration attended by 2000 people in Danville on December 3, honoring the Kentucky surgeon who performed the world's first successful ovariotomy in 1809. More than 32,100 stamps were sold on the first day and 315,000 were requested by mail. Federal officials, members of the Kentucky State Medical Association and the Kentucky Pharmaceutical and others joined in praise of Doctor McDowell's medical triumph. The stamp dedication address was made by Bert B. Barnes, Washington, Assistant Postmaster General.

Top Row, Left—A foursome who had much to do with the success of the celebration were: Francis Massie, M.D., Lexington, co-chairman of the KSMA McDowell Home Committee; Charles W. Sisk, M.D., Enos Swain and Jack Stith, all of Danville. Mr. Stith was the general chairman who spearheaded development and details of the December 3 ceremonies.

Top Row, Center—Congratulations are extended by Doctor Massie to Mr. Stith.

Top Row, Right—Congressman John C. Watts, Nicholasville, of the Sixth Congressional District, buys a souvenir booklet.

Center Row, Left—Paying homage to Doctor McDowell is KSMA President Irvin Abell, Jr., Louisville, principal speaker on the morning program.

Center Row, Right—Leaving the first post office west of the Alleghenies, after buying first day stamps, are Doctor Abell, Mrs. Abell and Carlisle Morse, M.D., Louisville. This post office, of which Doctor McDowell was the third postmaster, is now a shrine and was used in the December 3 sale of stamps.

Bottom Row—A group of the 150 persons who attended the luncheon following the ceremonies included, left to right: Mrs. Irvin Abell, Senator John Sherman Cooper, Somerset, one of the day's principal speakers; Doctor Abell, Mr. Stith, Doctor Massie and E. Crawford Myer, president of the Kentucky Pharmaceutical Association.

(Note: The addresses of Dr. Glenn Sonnedecker and John C. Burch, M.D., made at the dedication of the McDowell Apothecary Shop in Danville on August 14, 1959, appear on Pages 62-67 of this issue of The Journal.)

Journal MSMA Is Nation's Newest

A new state medical journal—the Journal of the Mississippi State Medical Association—made its debut on January 1. When the first issue rolled off the presses, the Mississippi Association became the 48th state to own and publish its official scientific journal and the 34th association member of the State Medical Journal Advertising Bureau.

The Journal MSMA is printed in Times Roman, the type used by the Journal of the Kentucky State Medical Association. Its editor is W. H. Anderson, M.D., Booneville, Miss.

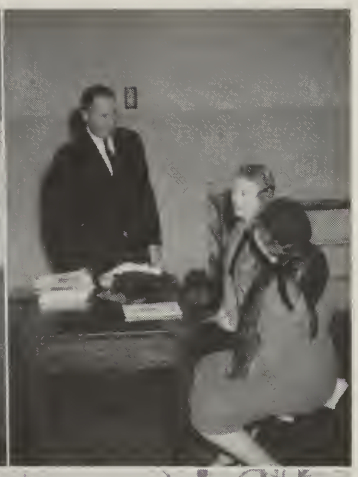
Dr. McIlvoy On Poison Control Unit

Daniel B. McIlvoy, Jr., M.D., Bowling Green, has been named vice-chairman of the Kentucky Poison Control Committee.

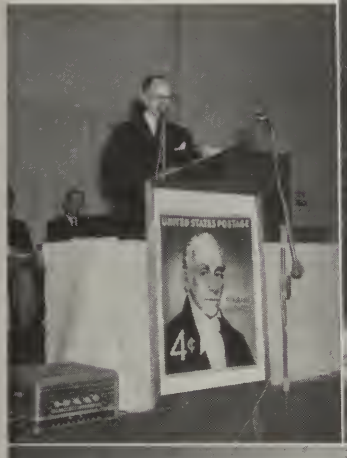
The program includes regional control centers in Louisville, Paducah, Fort Thomas, Bowling Green, Ashland, Harlan and Lexington. Smaller community centers are scattered throughout the state.







McDowell Stamp Day







Kentucky-Sponsored Amendment, Adopted by AMA House, Strengthens Medicine's Stand On Free-Choice Matter

New strength was added to medicine's position on the free choice of physicians when the American Medical Association's House of Delegates adopted a Kentucky-sponsored amendment to a Reference Committee report at the December 1-3, 1959, interim meeting of the House in Dallas, Texas.

The Reference Committee on Insurance and Medical Service considered four different resolutions reflecting strong dissatisfaction with the interpretations of the statement of the House of Delegates on the free-choice matter that grew out of the report of the Commission on Medical Care Plans at the June, 1959, meeting of the House of Delegates in Atlantic City. The amendment to the Reference Committee report offered by Robert C. Long, M.D., Louisville, junior AMA delegate from Kentucky, which passed the House by a vote of 121 to 58, read as follows:

"Lest there be any misunderstanding, we state unequivocally that the AMA firmly subscribes to freedom of choice of physician and free competition among physicians as being pre-requisites to optimal medical care. The benefits of any system which provide medical care must be judged on the degree to which it allows or abridges such freedom of choice and such competition."

The same Reference Committee considered twelve resolutions on the subject of relationships between physicians and hospitals. In making recommendation on these resolutions, which were accepted, the Reference Committee said, "To resolve any doubt on the position of the House of Delegates, your committee recommends that none of the above-numbered resolutions be adopted, but that the House of Delegates reaffirm the 1951 guides as its policy on hospital-physician relationships and that subsequent or inconsistent actions are considered superseding." (The KSMA Headquarters Office will, on request, be glad to procure a copy of these guides for any member.)

In an effort to help meet the need for increasing the number of physicians in the future, the creation of a Study Committee was approved by the House. This committee would made recommendations on a scholarship program; ascertain the limit to which medical schools might increase their student bodies; learn the number of universities that might add new schools, and investigate the financing of expansion and establishment of medical schools, the recruiting of well-qualified students to study medicine, and the possibility of relaxing geographic restrictions on the admission of students to medical schools. The committee will be asked to report in June, 1960.

Once more the matter of relative value studies was considered. The House reaffirmed its previous policy, approving in principle the conducting of relative value studies by each state medical society, rather than a nationwide study or a series of regional studies. The Committee on Medical Practices was asked to inform each state medical association of the purpose, scope, objectives, etc., of such studies, the problems which might be encountered, and the manner in which the results can be applied.

The House recognized, however, that some state medical associations are either not interested in relative value studies or are actively opposed to them. It was pointed out that since the regional conferences are educational in nature, the AMA House said it remains for each county and state medical association to accept or reject the idea of a study in its area.

In a report from the AMA Board of Trustees, it was learned that a laison committee to meet with a similar committee of the American Osteopathic Association to consider matters of joint interest had been appointed.

Once again the House of Delegates stated its support of the Blue Shield and directed the Council on Medical Service to submit at the June, 1960, meeting its recommendations concerning a policy statement of AMA relationships with Blue Shield plans. The House urged "use," not "abuse" of Blue Shield plans.

The House registered a strong vote of protest to the Veterans Administration urging more strict screening of non-service-connected disability patients admitted to Government hospitals. It also suggested that fees for consultative examinations under the programs of Bureau of Old Age and Survivor Insurance be adjudicated directly between the state medical association and the state agency involved.

The House asked each individual physician to wage "a vigorous, dynamic, and uncompromising fight" against Forand-type legislation. It urged active promotion and careful study of newly-developed guides for medical care of nursing homes and related facilities and called for an investigation of need, desirability, and feasibility of establishing a home for aged and retired physicians.

Many hailed the action of the House when it urged medical schools to include in their curriculum a course on political, social and economic aspects of medicine. The House also suggested that the AMA make available to school libraries information and literature showing the advantage of private medical care and the American free-enterprise system.

The House also reaffirmed the "suggested guides to relations between medical societies and voluntary health agencies" which had been adopted two years before in Philadelphia.

At the opening session of the House Tuesday, a total of $250,000 was contributed to the American Medical Education Foundation by six different states. Neighboing Indiana, along with California, New York, Utah, New Jersey, and Arizona were the contributors.

It was decided at this meeting to allow four days for the next interim meeting of the House instead of three, in order to provide more time for the reference committees to dispose of their reports.



GOLDEN WEDDING: Charles A. Vance, M.D., right, and Mrs. Vance of Lexington celebrated their 50th wedding anniversary with a reception at the Lexington Country Club on Sunday, November 22. Shown with them is their long-time friend, Richard G. Elliott, M.D., president-elect of KSMA. More than 400 relatives and friends attended the reception.

AMA and AHA to Accelerate Health Care Programs

The American Medical Association and the American Hospital Association are mobilizing their full resources to accelerate the development of adequately-financed health care programs for needy persons—especially the aged—according to a joint resolution issued by the boards of trustees of the two organizations on December 3.

The plan is to stimulate state and local components of the groups to work with local government toward adequate financing of high quality health care for the needy, supported by all community resources and necessary tax funds. Recognizing that effective medical care programs have already been established in some states and local communities, the resolution pointed out that such programs deserve increased support and stimulation.

The resolution voiced opposition of the AMA and AHA to the Forand bill. Such proposals, it stated, are not designed especially to assist the needy, since they apply to all social security beneficiaries and exclude the majority of needy persons who are not eligible for social security benefits.

Crippled Children Clinics Announced for State

The January schedule of clinics set up by the Kentucky Crippled Children Commission for children whose parents are indigent or unable to pay for total care have been announced by Marjorie K. Smith, M.D., Medical Director.

Appointments should be made through the Commission, P. O. Box 65, Shelby Station, Louisville 17, or its Out-Patient Department, c/o Cardinal Hill Convalescent Hospital, Versailles Pike, Lexington. Patients suffering from cleft lip and palate or cerebral palsy are not admitted directly to the clinics, but only on special referral.

Clinics scheduled for the remainder of January follow:

Louisville District, at Kosair Crippled Children Hospital—January 14, 19, 21, 22 and 28, orthopedic; January 15, scoliosis; January 20, cerebral palsy.

Lexington District, at Cardinal Hill Convalescent Hospital—January 15 and 22, orthopedic; January 21, plastic; January 27, cerebral palsy.

Covington District, at Treatment Center—January 27, cerebral palsy.

Paducah District, at West Kentucky Center for Handicapped Children—January 14, cerebral palsy.

Ashland District, at King's Daughters Hospital—January 26, orthopedic.

U. of L. Gets $30,000 Grant

The University of Louisville School of Medicine is one of 25 medical schools to receive $30,000 grants from the John and Mary R. Markle Foundation of New York, toward support of a medical scholar. The Louisville appointee is Arthur C. White, M.D., who will be allotted $6,000 annually for five years, beginning July 1, 1959.

Markle grants to medical education during 1958-59 totaled $920,000, with the Scholar in Medical Science program continuing to be the major interest, according to the annual report of the fund. The Foundation suggested more two-year medical schools to increase the number of doctors.

Medical Center Gets $120,140 Urban Renewal Grant

A grant of $120,140 for redeveloping the Medical Center area in Louisville was approved December 7 by the Urban Renewal Administration. The announcement was made in Washington by Senators John Sherman Cooper and Thruston Morton.

The grant paves the way for the University of Louisville to get started on construction of its proposed $2,780,000 medical-dental building at Floyd and Madison Streets. It also enables the City to agree to a contract with Louisville Central Area, Inc., for planning of the redevelopment areas.

The Medical Center area of 88 acres is to be bounded by Brook, Jefferson, Jackson and Broadway.

County Society Bylaws Revised

County medical societies which do not have bylaws, or those which wish to revise their bylaws, will find a guide in the newly-revised Model County Society Bylaws approved by the House of Delegates at the 1959 Annual Meeting of KSMA. Copies are available in the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville.

Redrafting of the Model County Society Bylaws, which had not been revised since 1905, was asked by the Bylaws Committee in 1958. The House of Delegates authorized the revision. Gaines Davis, legal counsel for KSMA, assisted the Committee.

President Appoints Dr. Teague

Russell E. Teague, M.D., Kentucky's Commissioner of Health, has been appointed by President Eisenhower to the nine-member National Water Pollution Control Advisory Board. The board advises, consults with and makes recommendations to the Surgeon General on policy relating to his responsibilities under the Federal Water Pollution Control Act.

Doctor Teague is a commissioner and ex-chairman of the Ohio River Valley Water Sanitation Commission, secretary of the Kentucky Water Pollution Control Commission, and a member of the Existing Programs Committee of the Kentucky Water Resources Committee. For the past three years he has been chairman of the Committee on Environmental Sanitation of the Association of State and Territorial Health Officers. The first Kentuckian appointed to the Advisory Board, he will serve three years.

AMEF Gifts Total $241,295

The American Medical Education Foundation was presented $241,295 in gifts from six state medical associations at the opening session of the House of Delegates at the AMA's 13th Clinical Meeting in Dallas, December 1-4. This compared to $591,780 for the 1958 January-to-November total, according to George F. Lull, M.D., president of AMEF.

The largest check, for $156,562, came from the California Medical Association. The Indiana State Medical Association was second with $35,570.



Alex J. Steigman, M.D., right, professor of pediatrics at the University of Louisvlle School of Medicine, accepts a check for $5,000 from Dr. George E. Farrar, Jr., medical director of Wyeth Laboratories. The grant is one of 20 awards totaling $100,000 made annually by the Philadelphia pharmaceutical manufacturing firm to selected medical schools and hospitals.

Rural Health Meeting In Michigan

The National Conference on Rural Health, sponsored by the AMA Council on Rural Health, is set for February 25-27 at the Pantlind Hotel in Grand Rapids, Mich. "Meeting Challenges With Responsibility" is the theme.

The Kentucky State Medical Association will be represented by Mitchell B. Denham, M.D., Maysville, chairman of the KSMA Committee on Rural Health, who is also chairman of the Kentucky Rural Health Council. The national conference was held in Wichita, Kansas, last year.

Medical Assistant's Role Filmed

A new 26-minute color film, "First Contact," emphasizing the key role played by the physician's medical assistant in creating good public relations, has been released by the American Medical Association. Prints for showings are available to medical societies through AMA's Department of Medical Motion Pictures and Television and to medical assistants groups through the headquarters of the American Association of Medical Assistants, 510 N. Dearborn, Chicago.

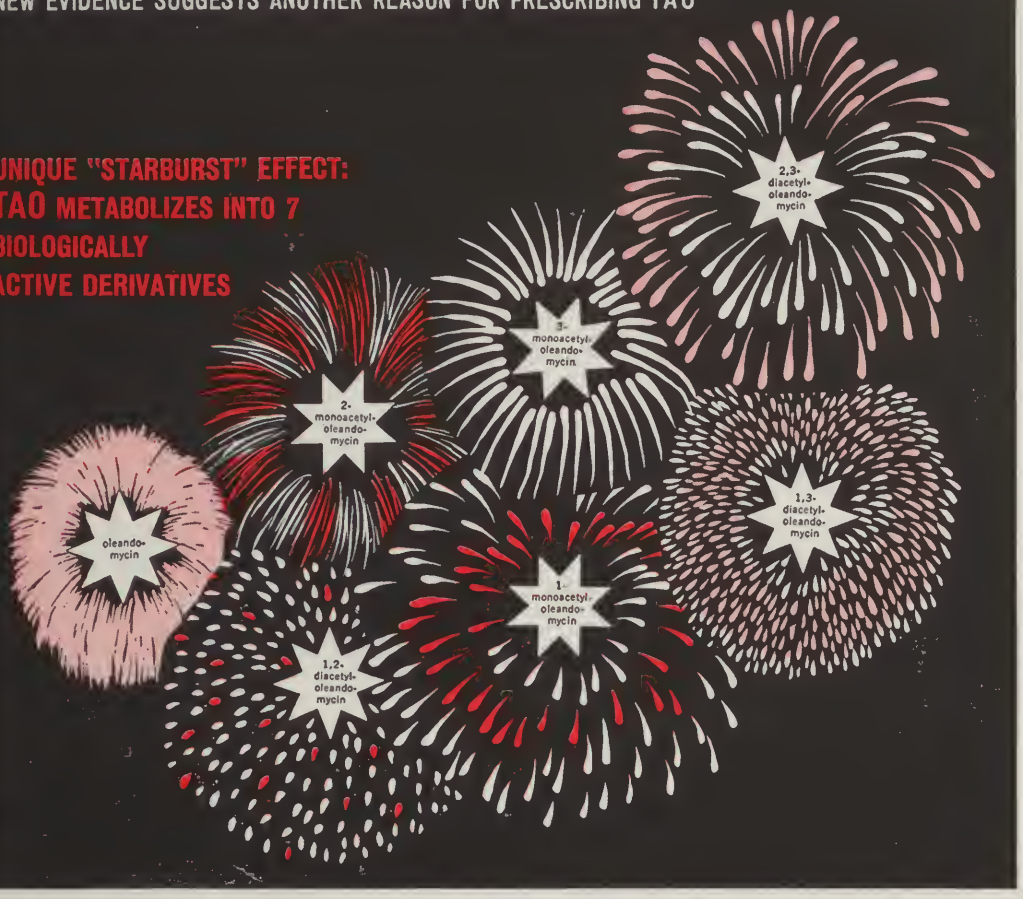
The importance of the film is stressed by N. L. Bosworth, M.D., Lexington, chairman of the KSMA Committee on Public Information and Service. The medical assistant is the physician's public relations ambassador, he said, and her understanding of good doctor-patient relations is invaluable to him.

Lexington M.D.'s Join KSMA

Two Lexington physicians are the newest members of the Kentucky State Medical Association. They are R. C. Morris, M.D., and K. S. Phillips, M.D.

NEW EVIDENCE SUGGESTS ANOTHER REASON FOR PRESCRIBING TAO

UNIQUE "STARBURST" EFFECT:
TAO METABOLIZES INTO 7
BIOLOGICALLY
ACTIVE DERIVATIVES



The impression that TAO is an unusually active antibiotic has steadily gained recognition by impressive clinical performance. Now come reports of **in vivo** and **in vitro** biological and biochemical evaluations that show TAO to be indeed unique.[1,2]

TAO differs from other antibiotics in that it is metabolized to multiple active compounds which **remain** active throughout their presence in the body. These 7 derivatives (in addition to TAO) show activity against common Gram-positive pathogens, including resistant strains of **Staph. aureus.**

In light of these findings, take another look at TAO performance: • 92% success in published cases of Gram-positive respiratory, skin, soft tissue and genitourinary infection • Effective against 78% of 64 "antibiotic-resistant" epidemic staphylococci. (In the same study, chloramphenicol was active against 52%; erythromycin against only 25%)[3] • No side effects in 94%; infrequent reactions mild and easily reversed • Quickly absorbed • Highly palatable.

Sound reasons to: Start with TAO to end 9 out of 10 common Gram-positive infections.

Supplied: TAO Capsules—250 mg., and 125 mg., bottles of 60. **TAO for Oral Suspension**—125 mg. per tsp. (5 cc.) when reconstituted; unusually palatable cherry flavor; 60 cc. bottle. Prescription only.

Other TAO forms available: TAO Pediatric Drops: flavorful, easy to administer. **TAO®-AC:** TAO analgesic, antihistaminic compound. **TAOMID®:** TAO with triple sulfas. **Intramuscular or Intravenous:** In clinical emergencies. Prescription only.

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designed for superior control of common Gram-positive infections

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Science for the World's Well-Being

CASE DISCUSSION

(Continued from Page 59)

rapid recovery following red cell and plasma restitution would add strength to either explanation.

The other neurological signs and symptoms were secondary to hypoxia and hypotension and indicate a diffuse cerebrovascular insufficiency with a major ischemic lesion in the right motor cortex.

Summary

To summarize, we have presented a case of temporary blindness, probably produced by compounded iatrogenic and patient factors. When dissected into proper perspective, the role of Rauwolfia alkaloid, prednisone, aspirin, and position in an elderly female with chronic hypertensive disease cannot be easily denied as a cause for this patient's blindness. No less disheartening was the lack of definite indications for the drugs used.

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ACP Has New Executive Director

Edward C. Rosenow, Jr., M.D., F.A.C.P., of Los Angeles, Calif., took office on January 1 as executive director of the American College of Physicians. He was appointed by the Board of Regents of the College to succeed Mr. Edward R. Loveland, F.A.C.P. (Hon.) who retired on December 31 after serving nearly 34 years as executive secretary of the College.

Doctor Rosenow, a native of Chicago, holds degrees from Carleton College, Harvard Medical School and the University of Minnesota, Mayo Foundation. He has been active in many medical societies and has held numerous medical-executive posts.

Pertinent Paragraphs

The 13th Annual Postgraduate Course on "Diseases of the Chest," sponsored by the Council on Postgraduate Medical Education of the American College of Chest Physicians and the Laennec Society of Philadelphia, is scheduled for March 14-18 at the Sheraton Hotel in Philadelphia. Tuition is $75 for ACCP members and $100 for non-members. The American College of Chest Physicians also announces its 26th Annual Meeting in Miami Beach, Fla., June 8-12, and the Sixth International Congress on Diseases of the Chest in Vienna, Austria, August 28-September 1.

The Gill Memorial Eye, Ear and Throat Hospital of Roanoke, Va., has announced April 4-9 as the date of its 33rd Annual Spring Congress in Opthalmology and Otolaryntology. Seventeen physicians from various parts of the country are listed as guest speakers.

MANY CANCERS ARE CURABLE . . . **NOW.** These are words of hope for the thousands of cancer patients who see their physicians *in time.*

Tremendous gains can be made . . . *now* . . . in three of the most common cancer sites: breast, cervix, rectum. The annual health checkup can often detect early cancers in these sites at a time when *presently available* methods of treatment can effect many more cures than are being achieved today.

The American Cancer Society, therefore, in its broad public education program, emphasizes the importance of annual physical examinations for all adults.

Together an alerted public and the medical profession can win a major victory over cancer . . . *now.*

AMERICAN CANCER SOCIETY®

News Items

Joseph James Lee, M.D., has opened offices in the Medical Arts Building and at 8603 Preston Highway, Louisville, with practice limited to obstetrics and gynecology. A native of Newark, N. J., Doctor Lee was graduate from the University of Louisville School of Medicine in 1950. After a year's internship in the Newark City Hospital, he served a year's residency in internal medicine, practiced medicine for three years, then served a three-year residency in obstetrics and gynecology at Louisville General Hospital. He held a fellowship with Laman Gray, M.D., at General Hospital for six months. Doctor Lee served four years in the U. S. Army and was a member of the Army Band.

Robert Mitchell Blake, M.D., has joined the Denham Clinic in Maysville, after completing two years with the U. S. Public Health Service, Division of Indian Health, where he attained the rank of major. Born in Nepton, Doctor Blake received his medical degree from the University of Louisville School of Medicine in 1956 and interned at Good Samaritan Hospital, Lexington. Before entering the Public Health Service, he practiced at Eastern State Hospital, Lexington, for several months.

Walter A. Cole, Jr., M.D., has terminated his practice at Radcliff and has opened an office at Hardinsburg, Breckinridge County.

Robert C. Long, M.D., Louisville, served as a member of the Reference Committee on Reports of Officers at the interim meeting of the AMA House of Delegates at Dallas, December 1-3.

John P. Walton, M.D., and Mrs. Walton of Central City celebrated their 50th wedding anniversary Sunday, November 22, with open house. They were married in Sonora on November 24, 1909, by Doctor Walton's father, the Rev. D. F. Walton.

Med School Appointments Made

Trustees of the University of Louisville at their December meeting approved the appointment of the following physicians to the university's School of Medicine: Douglas David, M.D., and William Hugh Gillespie, M.D., as instructors in medicine; Don L. Harmon, M.D., as instructor in surgery, and William T. Rumage, Jr., M.D., as research associate with the rank of assistant professor of surgery.

Other recent appointees include James Childers, M.D., as instructor in obstetrics and gynecology, and Bogdan Nedelkoff, as instructor in pathology.

Kentucky's Department of Mental Health spends only about $17,000 a year on research, according to figures released on December 9 at a mental-health-research workshop in Atlanta, sponsored by the Southern Regional Education Board. This compares with about $244,000 spent in Tennessee, $216,264 in Louisiana and $375,000 in Texas.

CITY VIEW SANITARIUM

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For the diagnosis and treatment of
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addictions to alcohol and drugs

Psychotherapy and occupational therapy

Electrical shock and insulin therapy as indicated

Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director

Prepaid Protection Extended To Federal Employees

Under a new law which becomes effective on July 1, Federal employees will have a choice of enrolling in a comprehensive Blue Cross-Blue Shield program, or of adopting a plan offered by commercial insurance. No employee will be required to sign up for any of the plans.

The amount the Government will contribute will be determined by the over-all cost of the program chosen—up to $2.80 a month for employee only and $6.75 a month for employee and family. Benefits have not been spelled out yet; however, each plan will have two "level of benefits" choices. Health benefits will not begin until the first pay period after June 30.

More than 750,000 Government employees are now enrolled in plans which Blue Cross-Blue Shield have made available through special group arrangements. Of some 32,000 Government employees in Kentucky, more than 15,000 are enrolled in Blue Cross-Blue Shield.

Oklahoman Gets 1959 GP Award

Chesley M. Martin, M.D., a general practitioner for 44 years in the small rural community of Elgin, Okla., was the AMA's choice as the outstanding family doctor of 1959. The honor was accorded by the AMA House of Delegates at the opening session of its 13th Clinical Meeting in Dallas on December 1.

The 70-year-old physician, 13th recipient of the General Practitioner of the Year award, was presented a gold medal and citation outlining his contribution by Leonard Larson, M.D., of Bismarck, N. D., chairman of the AMA Board of Trustees. Doctor Martin was described as "not just a physician" but "a doctor of humanity."

U.K. Medical Center Moves In

Nearly all departments of the University of Kentucky Medical Center moved in mid-December into the new Medical Science Building—the first unit of the new $26,000,000 Center. The move, a month ahead of schedule, involved about 45 persons who had been occupying cramped quarters in various buildings on the campus.

First occupant of the six-story building was the medical-library staff which moved about 50,000 bound volumes at the rate of about 50 shelves of books and journals a day.

State M.D.'s Attend Ob-Gyn Meet

Layman A. Gray, M.D., associate professor of obstetrics and gynecology at the University of Louisville School of Medicine, made the prinicipal address at the meeting of District 5, American Association of Obstetricians and Gynecologists, in Detroit, November 18. He spoke on Dr. Ephraim McDowell.

Other Kentucky physicians who attended were A. B. Barrett, M.D., Lexington; O. Leon Higdon, M.D., Paducah, and Robert Orr, M.D., Mayfield.

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Student AMA

Probably the most perplexing problem confronting the senior medical student is that of choosing a hospital in which he will interne. For three years he has lived a more or less planned life of study; now, he suddenly has to make a difficult decision which will affect his life for a year as well as influence his medical "know how" in subsequent years.

The attitudes and views reflected in your reporter's class regarding internships vary with the problem besetting the senior student himself. Seventy-five per cent of the class are married, and most of these are the parents of several children. Approximately seventy per cent tentatively plan to enter general practice. A very few are not financially embarrassed by being in debt as well as broke. The majority plan to practice medicine within Kentucky. None has voiced a desire to go into full-time research or teaching.

The choice is the student's; this is one time no other person can think for him. The consternation is written over the faces and is expressed in the attitudes of my fellow classmates. A month from this writing definite choices must be made; yet, a slim minority could say that they have positively decided on their hospitals at this time.

A few of the more verbose utterings include the following: "Should I interne in a teaching hospital where I will expand my knowledge of medicine, but where the remuneration is low?" "Perhaps a private hospital with adequate salary and a mediocre teaching program fits my needs more." "I'm getting tired of having residents around." "I've learned medicine as taught and practiced in Louisville; therefore, a change in scenery is in order."

The hospitals offering internships do not make the decisions much easier. The hospital recruitment programs are designed to attract bright young internes, but their "sales talk" is very confusing to the senior students. Each hospital is better than the next and, to prove as much, each offers "added inducements."

Fortunately, by the time you read this all decisions will have been made—some wise and some not so wise. Each student will try to feel well within himself because of his decision. I know all will be pleased that the internal conflict is over.

Robert K. McKechnie
President, U. of L. Chapter
Student AMA

Heart Symposium Set Mar. 9-10

The Annual Symposium on Cardiovascular Diseases, co-sponsored by the University of Louisville School of Medicine and the Heart Association of Louisville and Jefferson County, is announced for March 9 and 10 in the Brown Hotel Roof Garden. The opening session will begin at 9 a.m.

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In Memoriam

E. S. DUNHAM, M.D.
Edmonton
1904 - 1959

A heart attack suffered on November 27 in a doctor's office in Nashville proved fatal to E. S. Dunham, M.D., 55, of Edmonton. He had been in his office that morning before going to Nashville to see a heart specialist.

A 1931 graduate of the University of Louisville School of Medicine, Doctor Dunham had practiced in Edmonton for 26 years. He was active in organized medicine, was widely known and highly respected by his patients and colleagues.

JOHN HARVEY, M.D.
Lexington
1892 - 1959

John Harvey, M.D., chairman of the Lexington-Fayette County Board of Health, died on November 14 at St. Joseph Hospital, Lexington, after a three-month illness. He would have been 67 on December 3.

Doctor Harvey, who had practiced medicine in Lexington since 1924, served as a colonel during World War I. Born in Snow Hill, N. C., he took premedical training at North Carolina State College and was graduated from the University of Pennsylvania School of Medicine in 1920.

W. O. HOPPER, M.D.
Perryville
1872 - 1959

Walter O. Hopper, M.D., who retired five years ago after practicing medicine in the Perryville community for 53 years, died on December 5 at Ephraim McDowell Hospital, Danville.

Doctor Hopper, a 1901 graduate of the old Hospital College of Medicine in Louisville, delivered 2,300 babies during his long practice. Upon his retirement, he was granted life membership in the Boyle County Medical Society.

FRANK T. LINTON, M.D.
Princeton
1893 - 1959

Frank Terry Linton, M.D., physician, surgeon and civic leader in Princeton for 32 years, died on November 2 at his home there. He was 66.

A native of Ohio, Doctor Linton was graduated from the University of Cincinnati College of Medicine in 1920. He did postgraduate work at the Mayo Clinic and at the University of Chicago and Columbia University, and moved to Princeton from Iowa in 1927. Doctor Linton was a member of the KSMA, the AMA and SMA.

E. W. MILLER, M.D.
Hazel
1882 - 1959

Eunice Wilson Miller, M.D., a physician for 49 years, died of a heart attack at his home in Hazel on December 9. He was 77.

Doctor Miller was graduated from the Medical Department of the University of Louisville in 1910. He had practiced in Providence, Webster County, before locating in Hazel.

ROBERT W. SMITH, M.D.
Owensboro
1914 - 1959

Robert W. Smith, M.D., physician and surgeon, died on December 16 at his home in Owensboro at the age of 45.

A native Kentuckian, Doctor Smith was graduated from the Vanderbilt University School of Medicine in 1938.

Governor Honors Dr. Hiestand

Clement V. Hiestand, M.D., Campbellsville, was one of six Kentuckians honored with medallions by Governor A. B. Chandler on November 20 for distinguished and meritorious service to the Commonwealth. Doctor Hiestand was cited for his 63 years of active medical practice in Taylor, Casey, Green, LaRue, Marion and Adair counties and for his public services, which include eight years as mayor of Campbellsville.

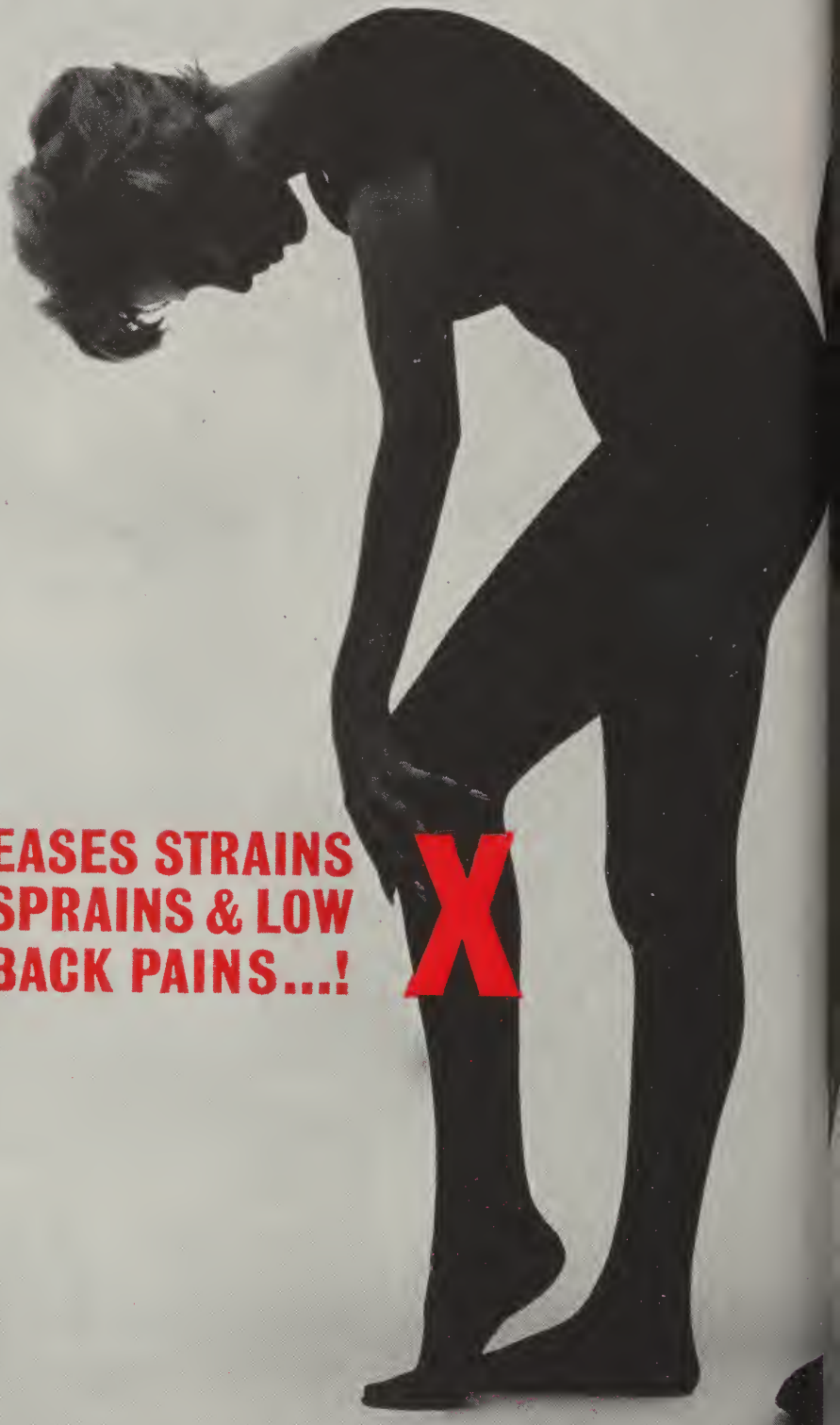
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1. Kuge, T.: To be published.

H-227

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Health Insurance After 65

(Continued from Page 16)

eligible under group programs. In this way, coverage including dependents is maintained for large numbers of persons who continue employment after age 65.

2. Instead of terminating at retirement, benefits are increasingly being provided under group plans for the retired employees and their dependents. Usually the employer pays all or a substantial part of the premium in these programs.
3. Through the conversion technique, the employee may continue his group insurance under an individual policy or contract without any requirement of insurability.
4. Plans are being issued to groups of older persons who are members of associations or clubs of retired persons or employees.
5. At least four companies have developed special programs for persons 65 and older being marketed through mass enrollment techniques without evidence of insurability.
6. Individually-issued policies are increasingly being made available to applicants over age 65.
7. Policies are being offered to younger adults on a lifetime basis with renewability guaranteed in the retirement years. A recent survey showed 85 companies are now issuing lifetime policies.
8. Issuance of paid-up policies at age 65. The policyholder pays for his retirement health insurance protection during his working years.
9. Physically impaired risks are now being successfully underwritten. More than 40 insurance companies now offer policies to broad classes of physically impaired people.

The insurance business is making every effort to promote the sale of insurance for people in retirement years and believes that the problem of financing health care costs of future older people will be substantially eliminated through the present voluntary mechanisms.

The fact that this is an area of concern to many groups is reflected in the number of legislative proposals which have been introduced in Congress during the past several years. The challenge confronting the insurance business is to demonstrate further the effectiveness of health insurance under voluntary sponsorship so government action can be minimized.

William P. Tate, Chairman
Kentucky Committee
Health Insurance Council

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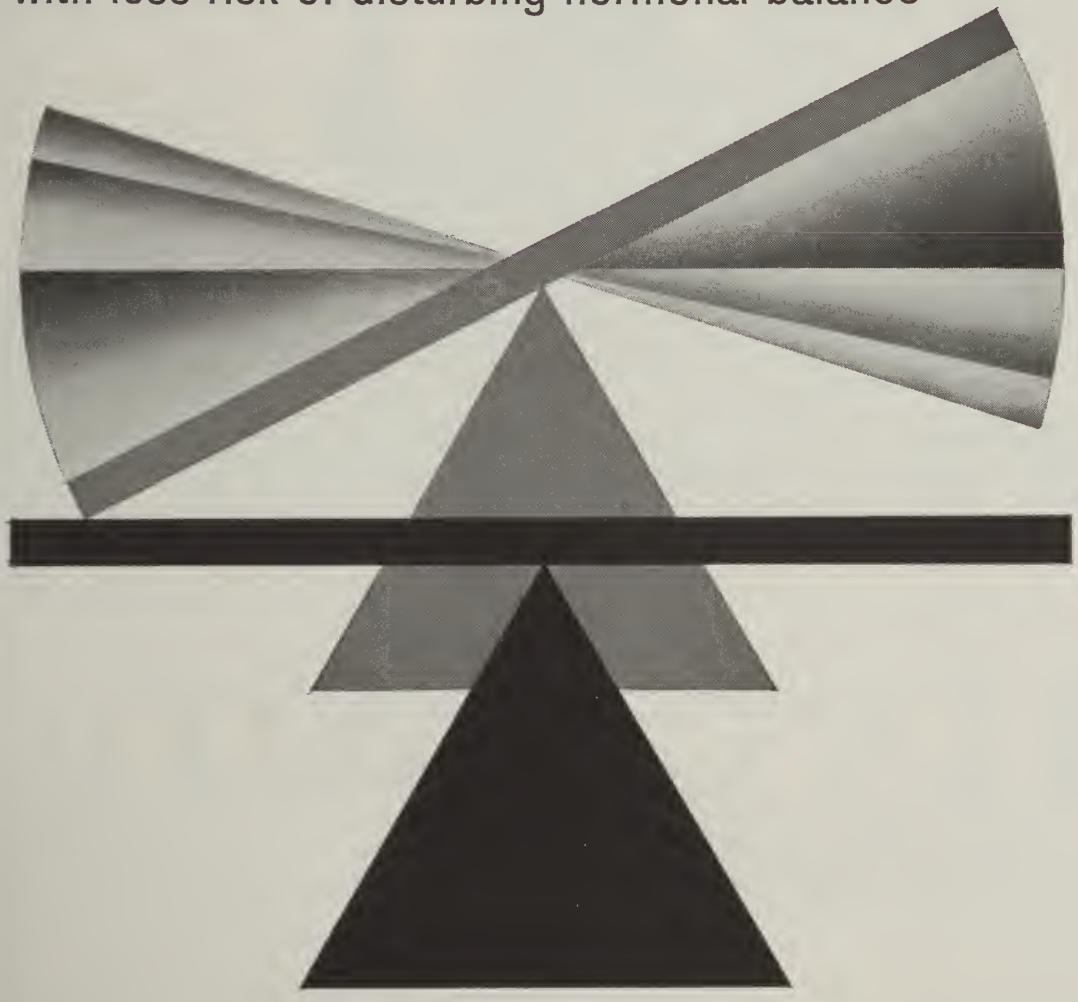
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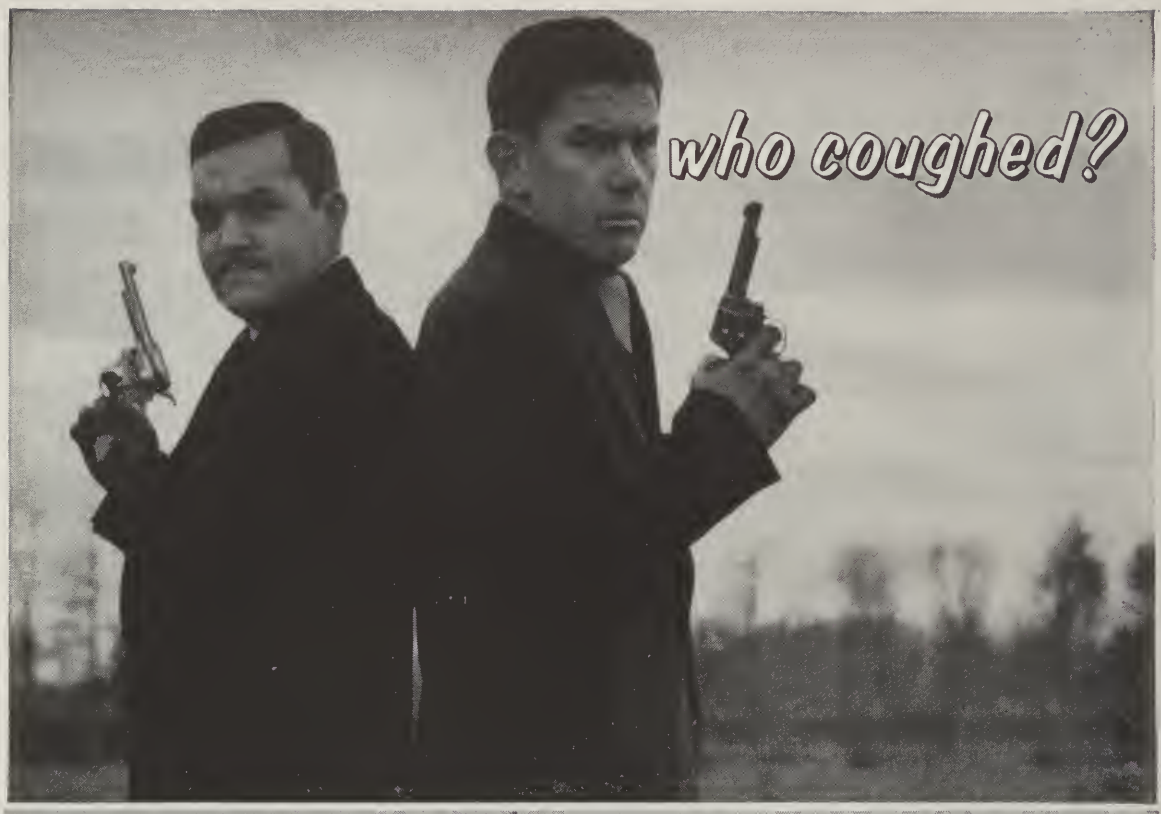
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1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

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Case Profile*

A 28-year-old married woman, a secretary in a booking agency, complained of severe and consistent pain and cramps in the abdomen during her menstrual periods. Psychologically, she described the first two days as "climbing the walls." Menarche occurred at age 13. She has a regular twenty-eight day menstrual cycle and a four day menstrual period.

Trancopal was given in a dose of 100 mg. four times a day for the first two days of the four day period. In addition to the relief of the dysmenorrhea she also noticed disappearance of a "bloated feeling" that had previously annoyed her. She has now been treated with Trancopal for one and one-half years with excellent results. Other medication, such as codeine or aspirin with codeine, had relieved the pain, but the patient had had to stay home. Because her father is a physician, many commercial preparations had been tried prior to Trancopal, but no success had been achieved.

Before taking Trancopal this patient missed one day of work every month. For the past year and a half she has not missed a day because of dysmenorrhea.



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Case Profile*

A 42-year-old truck driver and mover injured his back while moving a piano. The pain radiated from the sacral region down to the region of the Achilles tendon on the right side. X-rays for ruptured disc revealed nothing pertinent. The day of the injury he was given Trancopal immediately after the physical examination. Although 100 to 200 mg. three times a day were prescribed, the patient on his own responsibility increased the dosage of Trancopal to 400 mg. three times a day. This dosage was continued for three days and then gradually reduced over a ten day period. During this time, the patient continued to drive his truck. The muscle spasm was completely controlled and no apparent side effects were noted.

For the past six months, the patient has continued to take Trancopal 100 to 200 mg. as needed for muscle spasm, particularly during strenuous days.

**Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*

Turn page for complete listings of Indications and Dosage.

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Indications [1-6]

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Neck pain (torticollis)
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Rheumatoid arthritis
Osteoarthritis
Disc syndrome
Fibrositis
Ankle sprain, tennis elbow
Myositis
Postoperative muscle spasm

Psychogenic:

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Dysmenorrhea
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References: 1. Collective Study, Department of Medical Research, Winthrop Laboratories. 2. Lichtman, A. L.: New developments in muscle relaxant therapy, *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 3. Lichtman, A. L.: Relief of muscle spasm with a new central muscle relaxant, chlormezanone (Trancopal), Scientific Exhibit, Meeting of the International College of Surgeons, Miami Beach, Fla., Jan. 4-7, 1959. 4. Ganz, S. E.: Clinical evaluation of a new muscle relaxant (chlormethazanone), *J. Indiana M. A.* 52:1134, July, 1959. 5. Mullin, W. G., and Epifano, Leonard: Chlormezanone, a tranquilizing agent with potent skeletal muscle relaxant properties, *Am. Pract. Digest Treat.* 10:1743, Oct., 1959. 6. Shanaphy, J. F.: Chlormezanone (Trancopal) in the treatment of dysmenorrhea; a preliminary report, *Current Therap. Res.* 1:59, Oct., 1959.

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IN THE BOOKS



AN ATLAS OF NORMAL RADIOGRAPHIC ANATOMY: by Isadore Meschan, M.A., M.D., with the assistance of R. M. F. Farrer-Meschan, M.B., B.S. (Melbourne, Australia) M.D.; second edition published by W. B. Saunders Company, Philadelphia and London, 1959; 759 pages; 1,446 illustrations on 412 figures; price, $16.00.

This second edition is a revision and an expansion of the first edition, published in 1951. The atlas comprises seventeen chapters and an extensive index. The various body systems are examined in detail. Anatomical variations are fully shown. The excellent illustrations are generally in sets of three, showing a normal radiograph of the area studied, a labeled tracing of the film and the position of the x-ray tube and patient in obtaining the desired view.

Chapter I deals with the basic fundamentals of x-rays. Chapter II, on the Protection from X-radiation, is new and timely. The remaining chapters deal with various parts of the body and systems.

The chapter on Bone Growth and Development has been rewritten with the addition of more extensive bone-growth tables. Other improvements include the selective study of the posterior cranial fossa by pneumoencephalography, arteriography and venography of the brain, special studies of the heart and major vessels and roentgen anatomy of the biliary passages.

In the preface of the first edition, the authors state it is now recognized that some knowledge of the fundamentals of radiology is a requirement for any medical practice.

With this in mind, they have developed this Atlas for the teachers of morbid anatomy, radiology, clinical medicine and for the general practitioner. All of these will desire to have this basic volume in their library.

H. L. Townsend, M.D.

THE RELATION OF PSYCHIATRY TO PHARMACOLOGY: by Abraham Wikler, M.D.; published for the American Society for Pharmacology and Experimental Therapeutics by Williams and Wilkins, Co., Baltimore, Md; 322 pages; price, $4.

This is a review of previously published studies on the use of drugs in psychiatry by Doctor Wikler at the USPHS Hospital at Lexington, Kentucky. Although the book is unprepossessing as to appearance in its binding and somewhat difficult to read because of the nature of the compellation, it is a fascinating treatise on the problems of psychiatric research in general.

Doctor Wikler divides his book into two parts. The first section, "The Effects of Drugs on Human Behavior," deals with therapeutic procedures, "Psycho-Exploration," tranquilization, elevation of mood, diagnosis, and the production of model psychoses. The second section is entitled "Theories and Mechanisms of Drug Actions" in which he describes the biochemical mechanism of drugs, the neuro-physiological, and finally, the psychological aspects.

Doctor Wikler's extensive search of the literature supports his thesis of a need for "properly controlled studies on the comparative effects of a variety of drugs upon behavior, of varied, but carefully selected homogenous groups of subjects under varied but standardized experimental conditions and with varied but specific activities of the observer."

Although this book is prepared primarily for the research worker, it should be required reading for the clinician who may use the various methods which Doctor Wikler describes. It would also be interesting to have the author's penetrating method used in a survey of other treatment methods in psychiatry.

F. M. Gaines, M.D.

501 QUESTIONS AND ANSWERS IN ANATOMY: by Stanley D. Miroyiannis, Ph. D.; published by Vantage Press, New York, Washington and Hollywood, 1959; 332 pages; price, $5.00.

The current trend in qualifying examinations of many types and in State and National Board examinations for licensure is toward the use of the objective rather than the subjective type of question. Such an examination gives an opportunity to obtain specific information over a broad coverage in a given field. It also lends itself readily to mechanical grading.

But this type of question is quite inadequate to determine the examinee's over-all understanding of the subject or his ability to organize the pertinent materials in any given area.

501 Questions and Answers in Anatomy has attempted to prepare a student for either type of examination. For, in addition to some 250 pages of questions and answers ostensibly of the subjective type, there is an appendix of 67 pages listing over one thousand questions of the true or false, multiple choice, matching and completion variations of the objective type of question. These are without answers.

A list of standard textbooks and atlases is also appended.

The questions cover the fields of gross, microscopic and neuroanatomy, but the great majority by far are concerned with gross anatomy. Histology is quite inadequately covered. Functional anatomy is almost entirely omitted.

(Continued on Page 100)

IN THE BOOKS

(Continued fom Page 99)

It is difficult to determine the extent to which the questions cover the field of anatomy for the author purposely followed no logical sequence or system. Thus, questions one to four cover the right kidney, the lymphatic drainage of the breast, the air sinuses of the skull and the radio-ulnar joint.

While many of the questions of the first part are the "Discuss" or "Describe" variety, the majority are of the type "List the ——.," "Name the ——.," "Give the ——.," the answers to which require only list of structures. Others belong to the "Define," "What is?" and "Locate" categories.

The answers given to the discussion questions are frequently quite sketchy, very often incomplete and not too infrequently misleading and erroneous. Often the answer fails to satisfy all parts of the question asked.

The true or false questions vary in complexity from "The foramen magnum is located in the orbit of the eye" to "The folium vermis extends laterally into the superior semilunar lobule separated from the inferior semilunar lobule, which belongs to the tuber, by the horizontal cerebellar fissure, which roughly marks the boundary between the superior and inferior surfaces."

The book has not been well edited. Besides numerous typographical errors, many questions are poorly worded; many are quite ambiguous.

Despite much listing of factual information one would hesitate to recommend this volume to any student who wishes to prepare himself for a comprehensive examination in anatomy.

Arch E. Cole, Ph.D.
Professor of Anatomy

County Society Reports

McCracken

Allocation of $500 to the Public Relations and Public Health Committees to further passage of the fluoridation bill was voted at the October meeting of the McCracken County Medical Society.

The request of Eugene Blake, M.D., for inactive membership in the society was approved.

William B. Haley, M.D., announced that a film on the Emergency Hospital is now available.

The Relative Value Study, explained in a letter from Garnett J. Sweeney, M.D., chairman of the KSMA Council, was disapproved by the members present on the grounds that it was premature and that other projects should be completed before funds were made available for such a study.

Norman A. Parrott, M.D., announced that Paducah undertakers had complained of delay in processing of death certificates.

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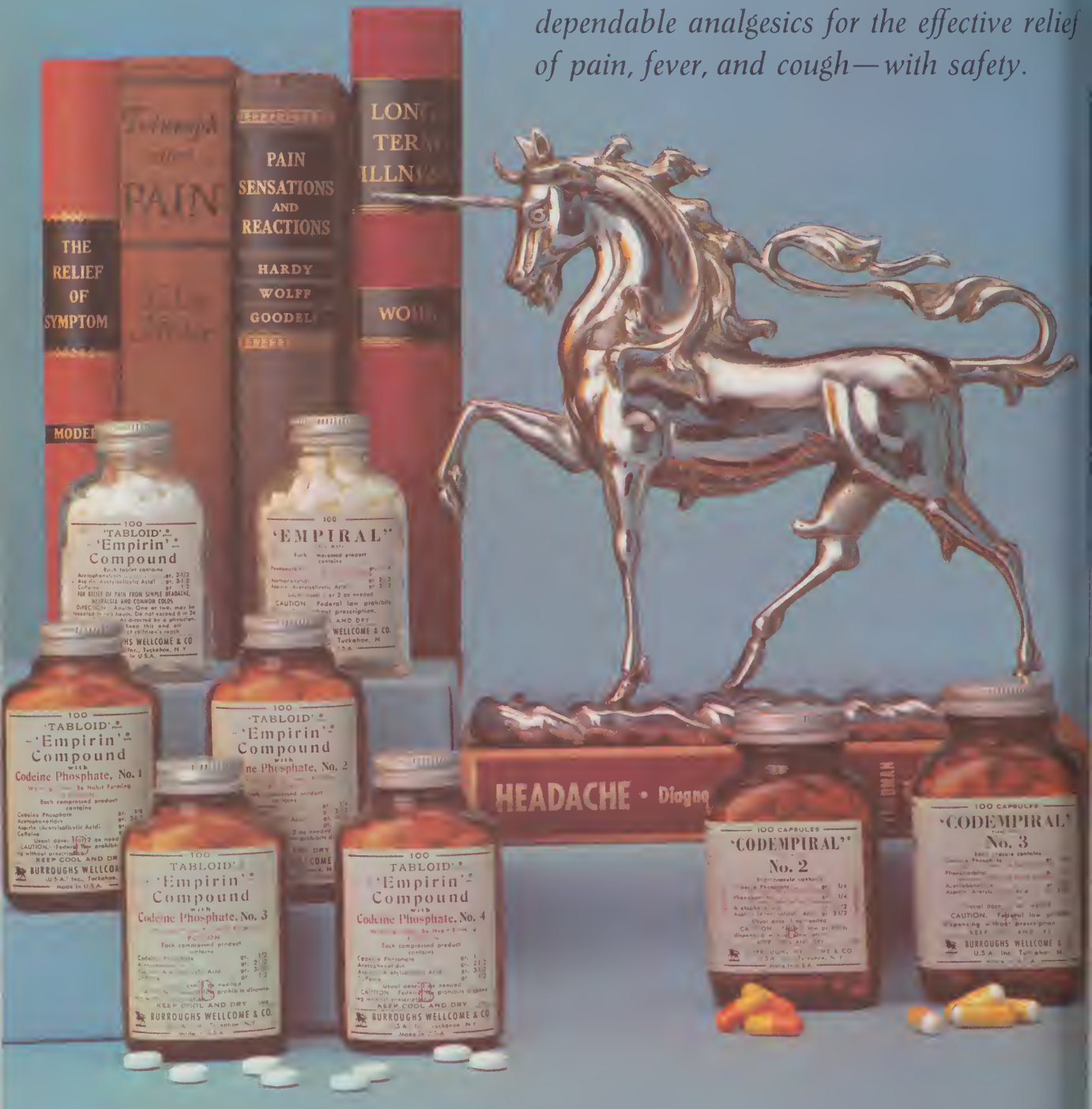
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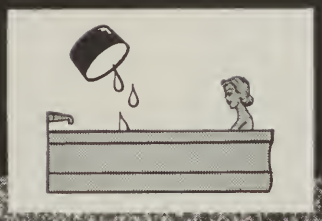
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1. Spoor, H. J.: N. Y. State J. Med. Oct. 15, 1958

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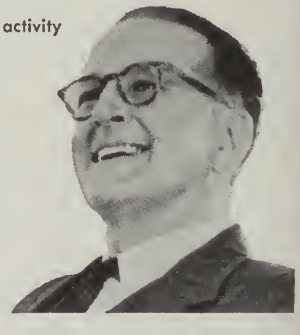
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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



Case #50: This patient was a 41-year-old married white gravida 14 para 13 whose L M P was April 1, 1958, making her expected date approximately January 6, 1959. Her past history was significant in that she had a history of placenta praevia lateralis with two previous deliveries and was delivered vaginally.

She consulted her physician for this pregnancy in her fourth month and had no complications.

Month of Pregnancy

	1	2	3	4	5	6	7	8	9 1	2	3	4
Date				8-16	9-13	10-18	11-15					
Blood Pressure				110/60	120/60	120/60	120/60					
Weight				164½	164¾	168	168					
Urine				neg	neg	neg	neg					

Rh+ VDRL Non-reactive

She saw her physician at 3:30 P.M. in his office on the afternoon of her death and had normal findings. No pelvic was done as she had no complaints. She had no history of bleeding during this pregnancy.

She accompanied her husband to town after leaving the doctor's office and returned home and prepared supper. While eating she had a "massive vaginal hemorrhage" around 5:30 P.M. She called her physician, who instructed her to go immediately to the hospital. There was a time lag due to difficulty in getting an ambulance and she arrived at the hospital at 6:55 P.M. She appeared cold and was clammy and had marked pallor. Her blood pressure was 100/60, pulse 98, Hgb 8.4 grams, WBC 20,750, with 54% PMN, Hematocrit 30%.

Intravenous fluids were immediately started and preparations were made for an emergency section. There was a period of 20-25 minutes required as some surgery was in process at the time. On vaginal examination the cervix was 2 fingers dilated with placental tissue palpable.

An emergency section was done under gas oxygen anesthesia with delivery of a 5 lb, 1½ oz female, at 7:53 P.M. The section, low cervical, was started at 7:48 P.M. and the abdominal closure was completed at 8:45 P.M., when the patient was returned to her room in "fair condition."

The following information is from the nurses' notes: At 8:45 P.M. she was returned to her room; the blood had infiltrated and it was restarted by the anesthetist. She was given 100 mg. of Demerol. At 9:00 P.M. the nurses noted she had a moderate amount of vaginal bleeding. Her skin was still cold and clammy. She was sleeping. That pint of blood was absorbed and 500 cc more was started with the same needle. She still was having a "moderate amount of vaginal bleeding" at 9:15 P.M. Her blood pressure was 98/50.

At 9:45 P.M. she began to react; the blood was absorbed, she was still having a moderate amount of vaginal bleeding and her blood pressure was 96/50. At 10:15 P.M. her blood pressure was 104/60, the pulse was weak and she was cold and clammy.

At 10:30 P.M. she again became restless. 1/6 gr. morphine was ordered and the anesthetist saw the patient. One ampule of adrenalin was given stat., and 500 cc of blood was started intravenously.

She expired at 11:10 P.M., 11-15-58.

Autopsy was requested but the husband refused the permit.

Cause of death listed on the certificate: terminal shock secondary to hemorrhage from placenta previa.

Comment

The Committee felt this case had preventable factors and must be considered a direct obstetric death due to hemorrhage.

There was a delay on the part of the family of the patient in getting her to the hospital even though the distance was not far. One hour was lost. She was in the hospital about one hour before the emergency section was started, although it was carried out without difficulty and she was returned to her room in what was described as "fair condition." It was at this point the patient should have been watched more closely. With the continued moderate amount of vaginal bleeding intravenous pitocin might have helped produce more efficient uterine contractions, since the placenta was implanted in the lower uterine segment where the contractible muscular component of the uterus is reduced. Intrauterine packing plus blood under pressure might have altered the outcome. There may be a place for cortisone in cases of acute shock like this; certainly there is more rationale for its administration along with the oxytocics and blood than intravenous Premarin as has been used in the past.

Since the section was completed at 8:45 P.M. and the patient expired at 11:10 P.M. almost two hours later, in retrospect possibly reopening the abdomen and bilaterally ligating the hypogastric vessels might have helped control the bleeding.

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PUBLIC HEALTH PAGE

Influenza

RUSSELL E. TEAGUE, M.D.

Commissioner of Health, Commonwealth of Kentucky

WITH the onset of cold weather, the season for respiratory infections has arrived. The respiratory infection which will probably cause the greatest concern is influenza. During the past six months, influenza surveillance has been reported from Central and South America, Australia, the Philippines, India and Africa. The outbreaks in the Far East and Western Pacific were primarily due to type A_2 (Asian), whereas those occurring in the Americas were of mixed etiology, A_2 and B.

During the summer and fall of 1959, influenza virus infections have occurred in the U.S. with types A_2 and B being identified. These two types were identified in the Kentucky cases of last winter.

The Kentucky State Department of Health laboratories have been asked again to participate as a Collaborating Laboratory in the World Health Organization Influenza Program. Success in such participation depends upon the private practitioners and county health departments which the laboratory serves.

The laboratory will be happy to receive serum specimens (acute and convalescent) and throat washings from patients so that complement fixation and hemogglutination-inhibition tests may be carried out on the serum specimens and chick-embryo isolation procedures may be carried out in throat washings. Inasmuch as the influenza virus does not survive shipment to the laboratory at ordinary temperatures, such throat washings must be shipped packed in dry ice. Acute and convalescent serum specimens should be sent because only by observing a rise in antibody titer (usually 4-fold) can the test be interpreted accurately. It is important to have an immunization history accompany the specimens.

The number of viruses recognized as capable of causing respiratory disease is growing each year. The laboratory will attempt to determine the etiological agent when the influenza virus has not been isolated. This situation is a challenging one and attempts will be made to identify such agents as the parainfluenza, reo, coxsackie and adenoviruses. In addition, here in Kentucky, consideration must be given to respiratory histoplasmosis because it stimulates influenza.

Success in controlling a respiratory disease such as influenza is dependent on immunizing a large segment of the population. The problem is complicated with influenza, however, because of antigenic mutants arising, against which the population has not been immunized. To such mutants is attributed the failure of some of the earlier influenza vaccines.

Today, new antigenic mutants are being added to current influenza vaccines so that broad coverage will be given to the immunized person. Unfortunately, it is impossible to predict when such new antigenic mutants will arise. The best that can be done is to immunize those individuals who will be most affected by an influenza infection (the aged, the debilitated, the key personnel, nurses, physicians, etc.). Such immunizations should be carried out early in the "flu" season because it takes at least two weeks for antibodies to develop to sufficient titer to afford protection.


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- unsurpassed broad-spectrum range of activity[4,6,10-12,14]
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- effectiveness against infection[2-5,7,9,11,12]
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*Activity level is a far more meaningful basis of comparison than quantitative blood levels, as Hirsch and Finland note. Action upon pathogens is the ultimate value.
(Hirsch, H. A. and Finland, M.: Antibacterial Activity of Serum of Normal Subjects after Oral Doses of Demethylchlortetracycline, Chlortetracycline and Oxytetracycline. *New England J. Med.* 260:1099 (May 28) 1959.)

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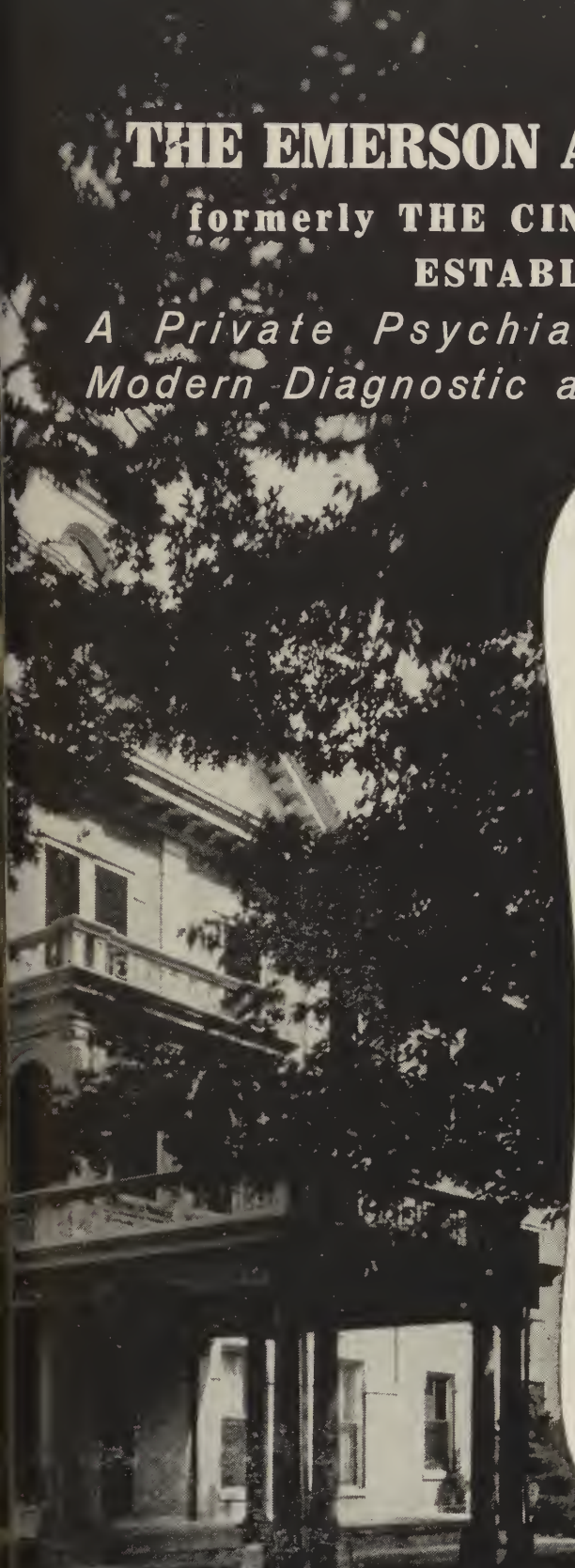
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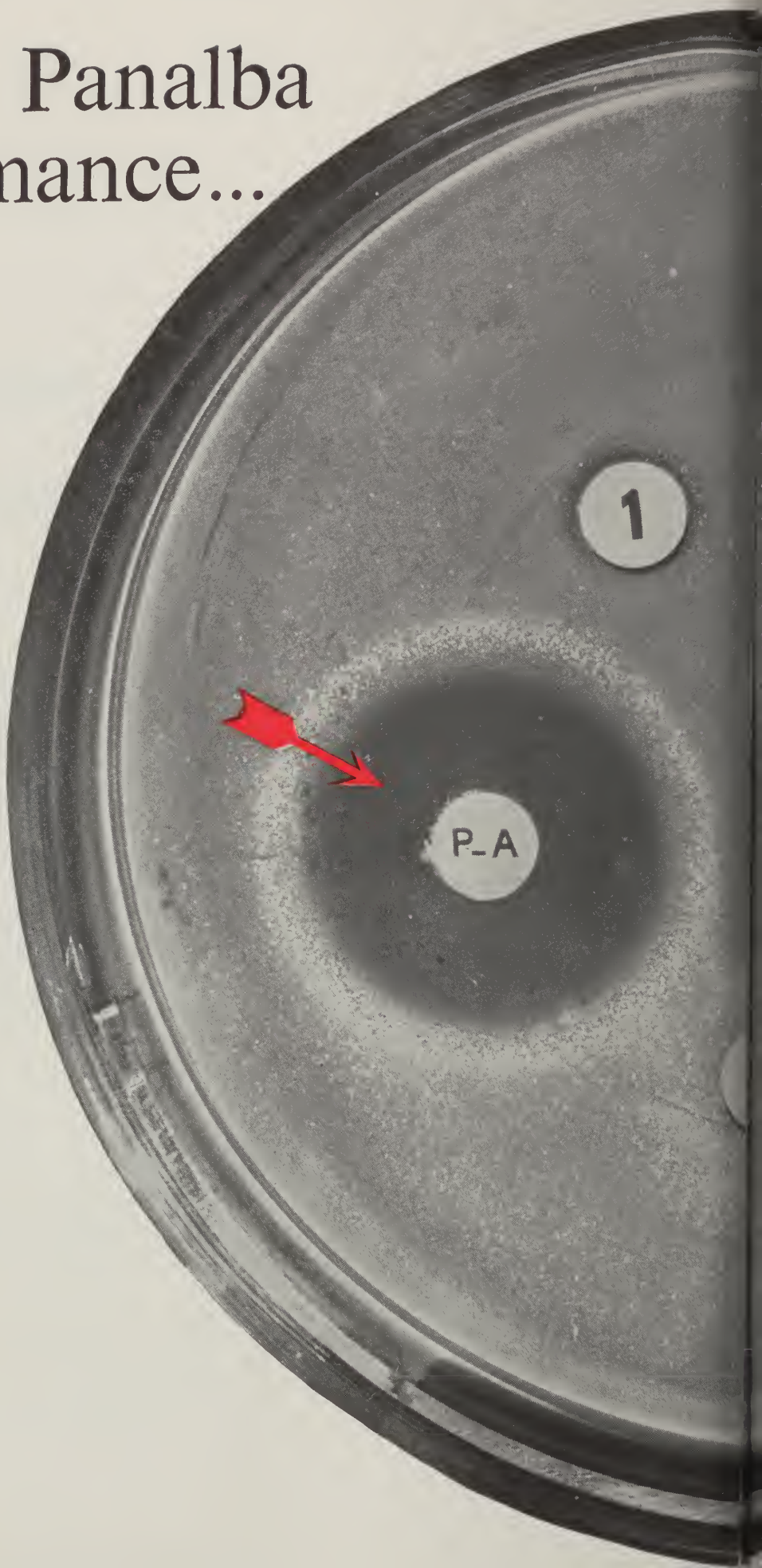
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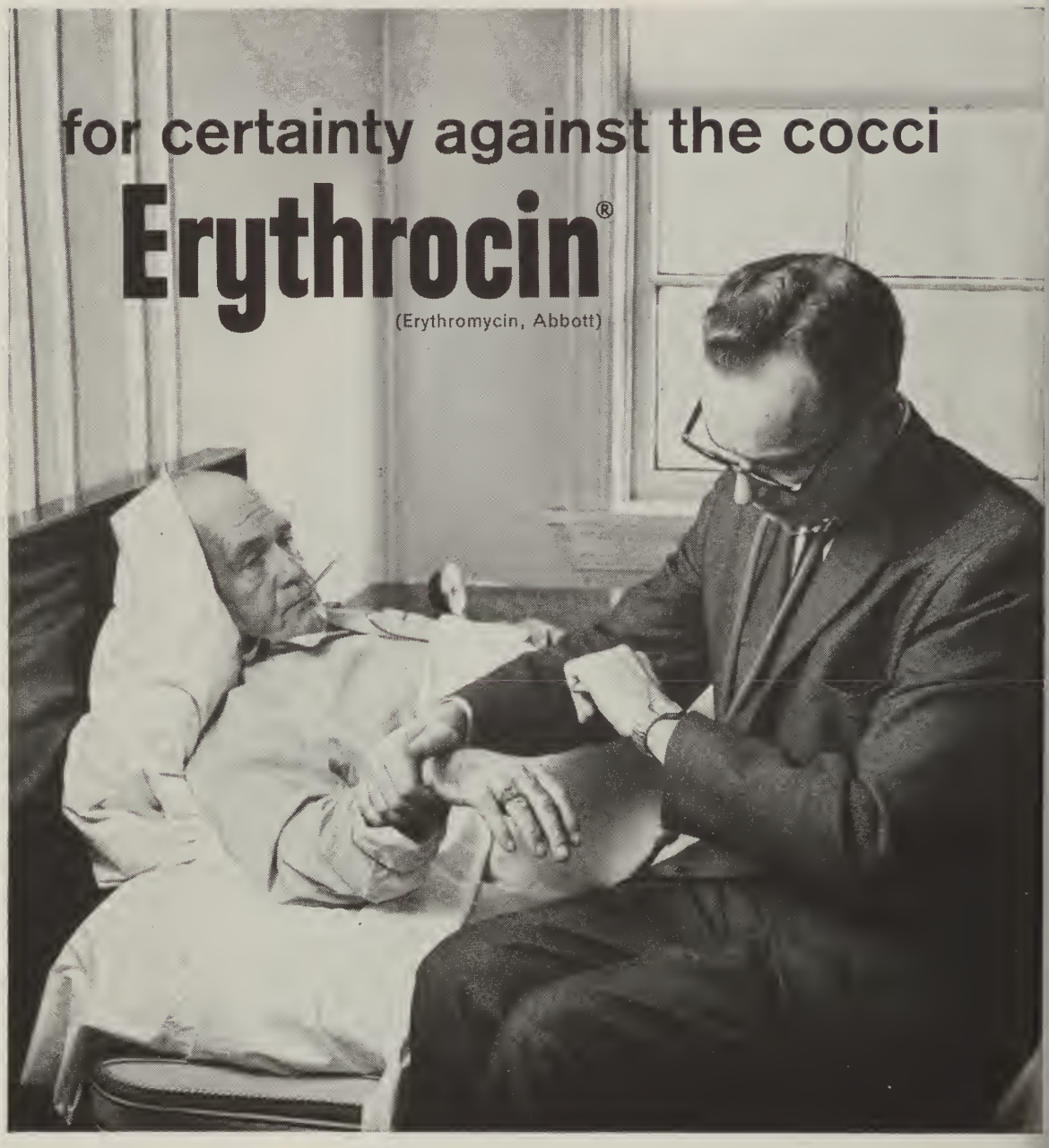
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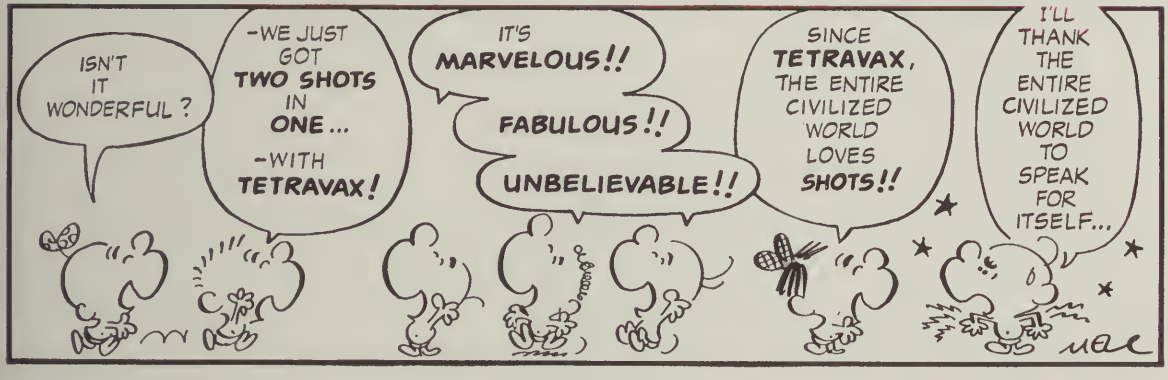
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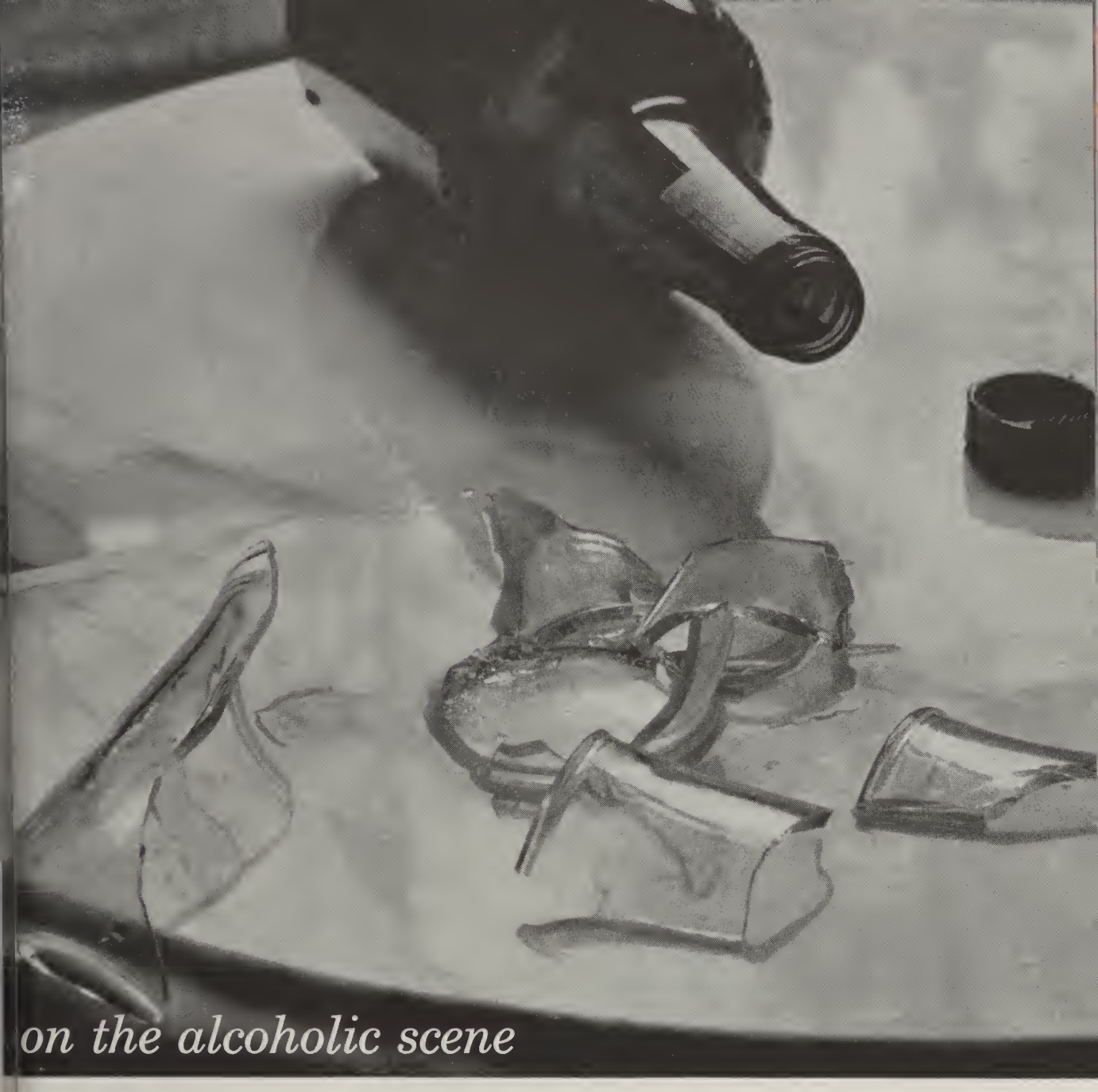
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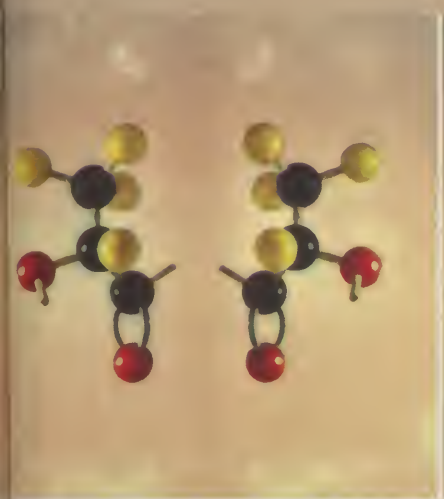
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MANY STAPH STRAINS MORE SENSITIVE TO SYNCILLIN

BRISTOL

ORIGIN OF A NEW SYNTHETIC PENICILLIN

In March, 1957, Dr. John C. Sheehan of the Massachusetts Institute of Technology announced the total synthesis of penicillin from common raw materials, thus solving a problem which had baffled research workers for more than 15 years. Although total synthesis was not commercially practicable, this work, sponsored by Bristol Laboratories, made possible the subsequent synthesis of new penicillins not occurring in nature. Later scientists at Beecham Laboratories in England discovered that a key intermediate (6-aminopenicillanic acid) could be produced by a fermentation process. With these achievements, large scale production of synthetic penicillins became feasible.

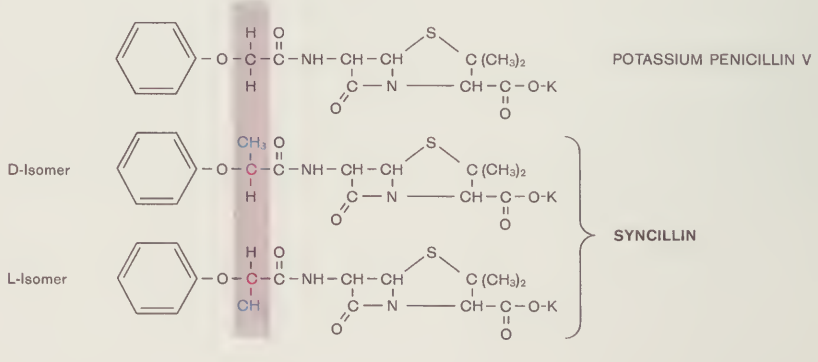
Organic chemists at Bristol then embarked upon an intensive program to develop better penicillins. Over five hundred were synthesized and underwent preliminary screening. Forty-six showed sufficient promise to warrant further investigation. Extensive microbiological, pharmacological, and clinical screening indicated that one compound, SYNCILLIN, had advantages of major importance over other penicillins.

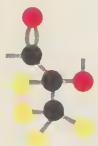
SYNCILLIN is the N-acylation product of 6-aminopenicillanic acid and α-phenoxypropionic acid (the phenylether of lactic acid). It is freely soluble in water and remarkably resistant to decomposition by acid. The acid stability of SYNCILLIN is equivalent to that of penicillin V at pH 2 and pH 3 at 37° C.[1]

SIGNIFICANCE OF MOLECULAR ASYMMETRY AND ISOMERIC COMPLEMENTARITY

SYNCILLIN has a molecular configuration similar to penicillin V, but contains an additional CH_3 group so positioned as to render the adjacent carbon atom asymmetric. (In the formulae below, the added CH_3 group is shown in blue and the asymmetric carbon atom in red.) As a result, SYNCILLIN occurs as a mixture of two isomers.

Each isomer has been synthesized in essentially pure form and found to possess distinctive chemical and biological properties. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. As produced, SYNCILLIN is a mixture of the L-isomer and the D-isomer. As will be shown later, the antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than either isomer alone against many organisms. This phenomenon is referred to here as *isomeric complementarity*.





SYNCILLIN

major therapeutic advantages accompany molecular asymmetry

ISOMERIC COMPLEMENTARITY DEMONSTRATED IN VITRO

The *in vitro* minimum inhibitory concentration (MIC) of SYNCILLIN and of each of its two component isomers was determined for a variety of common pathogens and laboratory test organisms. As may be seen from Table 1, all three are highly effective against penicillin-susceptible staphylococci and against pneumococci, streptococci, gonococci, and corynebacteria; all are ineffective against Salmonella, *E. coli*, and other gram-negative coliform bacilli.

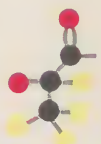
SYNCILLIN was more active against many of the test strains including some streptococci and staphylococci than either of its components. This demonstrates *in vitro* the phenomenon of isomeric complementarity.

TABLE 1

Minimum Concentrations of SYNCILLIN and Components Required to Inhibit a Wide Range of Bacteria

	Minimum Inhibitory Concentration (MIC) in Micrograms per Milliliter		
	L-Isomer	D-Isomer	SYNCILLIN
Bacillus anthracis	0.06	0.25	0.03
Bacillus cereus	12.5	100	25
Bacillus circulans ATCC 9961	6.25	6.25	6.25
Corynebacterium xerosis	0.06	0.125	0.03
*Diplococcus pneumoniae	0.06	0.06	0.06
Escherichia coli ATCC 8739	>100	>100	>100
Gaffkya tetragena	0.015	0.03	0.015
Micrococcus flavus	0.015	0.125	0.015
Salmonella paratyphi A	25	50	25
Salmonella typhosa	>100	>100	>100
Sarcina lutea ATCC 10054	0.007	0.12	0.007
Shigella sonnei	100	100	100
Staphylococcus aureus 209P	0.06	0.25	0.03
Staphylococcus aureus var. Smith	0.03	0.125	0.03
Streptococcus agalactiae ATCC 1077	0.03	0.06	0.03
Streptococcus dysgalactiae ATCC 9926	0.03	0.06	0.03
Streptococcus faecalis PCI 1305	6.25	25	6.25
*Streptococcus pyogenes 203	0.06	0.06	0.06
*Streptococcus pyogenes Digonnet	0.03	0.15	0.06
Streptococcus pyogenes 2320	0.06	0.06	0.03
Streptococcus pyogenes 23586	0.06	0.06	0.06
Vibrio comma	50	25	25

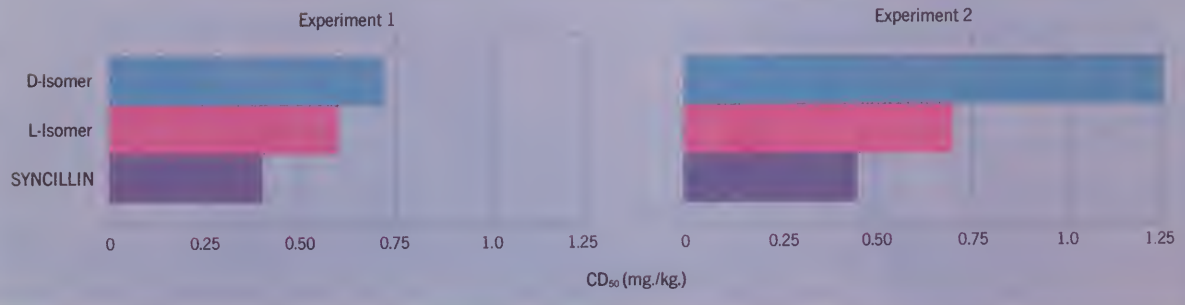
Serial dilution technique in heart infusion broth *10% serum added



ISOMERIC COMPLEMENTARITY CONFIRMED IN VIVO

To determine the median curative dose (CD_{50}) mice were infected with 100 times the lethal dose of *Staphylococcus aureus*. Each penicillin being tested was administered intramuscularly at the same time, and the dose required to cure half the animals determined. The greater effect of the mixture of the two isomers (SYNCILLIN) is shown in two independent experiments. (See Figure 1.) Note that isomeric complementarity is thus confirmed *in vivo*.

FIGURE 1 — Median Curative Dose (CD_{50}) for *Staphylococcus aureus* (var. Smith) Infections

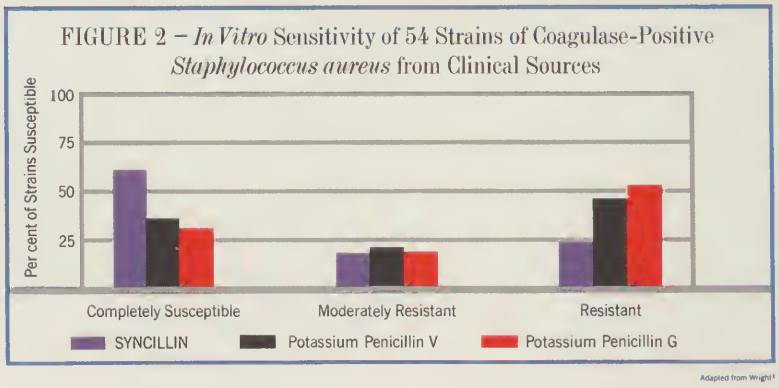


MANY STRAINS OF STAPHYLOCOCCI MORE SENSITIVE TO SYNCILLIN

SYNCILLIN has been tested against a large number of strains of *Staphylococcus aureus* isolated from clinical sources. Many organisms resistant to potassium penicillin G and potassium penicillin V proved sensitive to SYNCILLIN.

Wright[2] performed sensitivity studies on 54 strains, the majority of which were resistant or moderately resistant to penicillin V and penicillin G. Thirty-two (60%) of the strains were sensitive to SYNCILLIN, approximately twice as many as with the other penicillins. (See Figure 2.) In two-thirds of the isolates, SYNCILLIN produced inhibition at concentrations lower than those required for either of the other antibiotics. One strain was more sensitive to penicillin G.

FIGURE 2 – *In Vitro* Sensitivity of 54 Strains of Coagulase-Positive *Staphylococcus aureus* from Clinical Sources



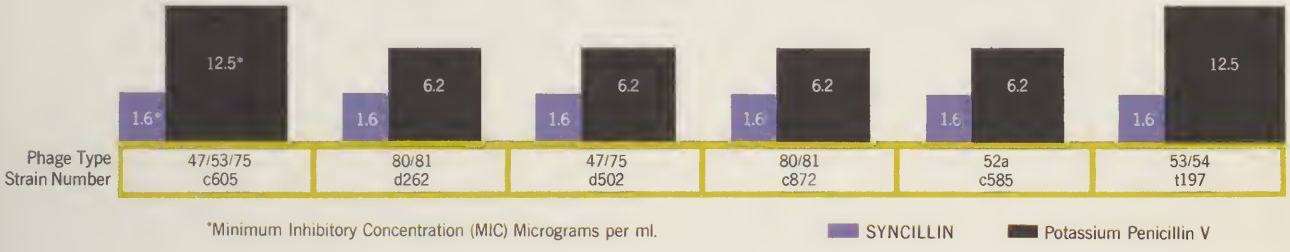
Adapted from Wright[2]



Of equal interest are the findings of White.[3] Six penicillin-resistant strains of staphylococci were isolated from hospital infections. None was sensitive to potassium penicillin V. All were sensitive to SYNCILLIN. (See Figure 3.)

FIGURE 3

Minimum Concentrations of SYNCILLIN Required to Inhibit
Hospital Strains of *Staphylococcus aureus* Resistant to Potassium Penicillin V

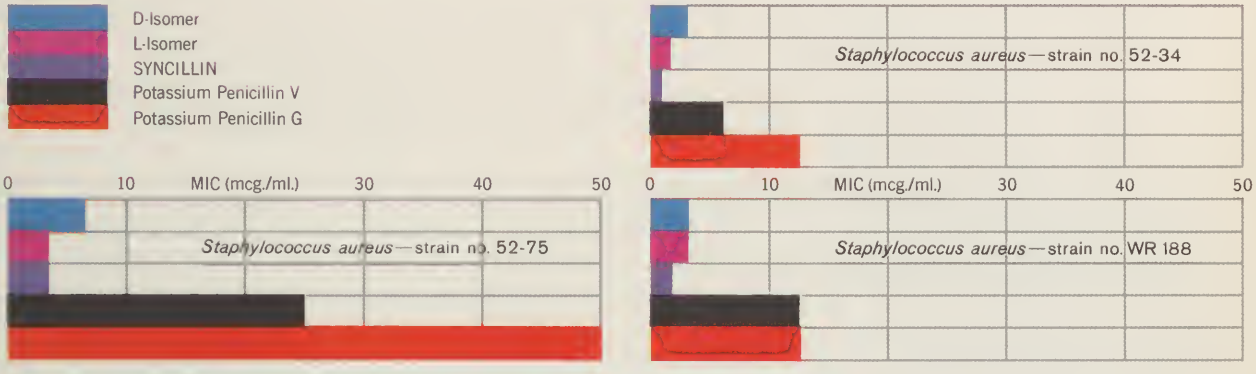


The efficacy of SYNCILLIN against the type 80/81 Staphylococcus (dangerous and widespread in hospitals) is worthy of special attention.

The complementary action of the component isomers is also seen with strains of staphylococci resistant to penicillins. Note that SYNCILLIN is more effective than either isomer against strains 52-34 and WR 188. (See Figure 4.) Against all three strains, SYNCILLIN is effective at concentrations below serum levels, while penicillins V and G are ineffective.

FIGURE 4

Minimum Inhibitory Concentrations (MIC) for Coagulase-Positive
Penicillin-Resistant Strains of *Staphylococcus aureus*



Isomeric complementarity has thus been demonstrated for:

—— *certain penicillin-susceptible streptococci, staphylococci and corynebacteria* in vitro *(Table 1)*

—— *penicillin-susceptible staphylococci* in vivo *(Figure 1)*

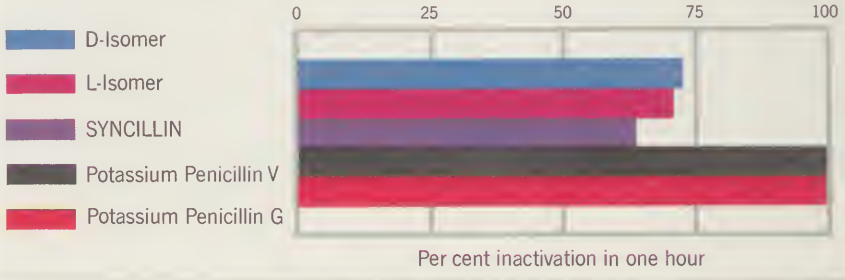
—— *penicillin-resistant staphylococci* in vitro *(Figure 4)*

ISOMERIC COMPLEMENTARITY SHOWN BY REDUCED RATE OF INACTIVATION BY PENICILLINASE

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms.[4] As shown in Figure 5, SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers – a further demonstration of isomeric complementarity. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V and penicillin G.

Resistance to SYNCILLIN develops in a slow, step-wise manner characteristic of other penicillins, in contrast to the usually rapid development of resistance to streptomycin.

FIGURE 5—Effect of Staphylococcal Penicillinase on Different Penicillins

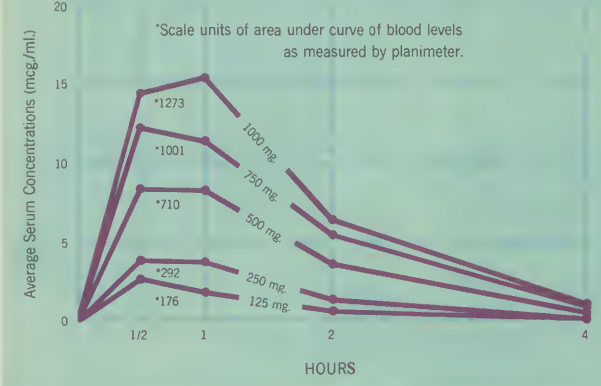


ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSAGE

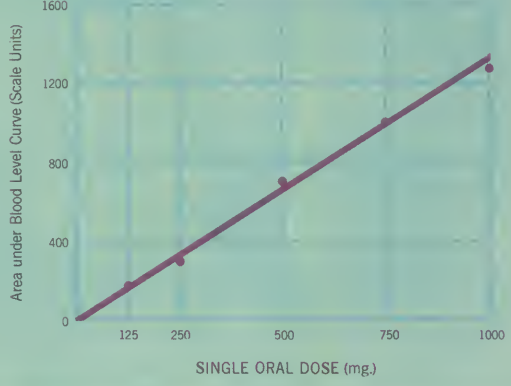
Cronk[5] studied blood levels after administering varying amounts of SYNCILLIN. (Figure 6.) Total antibiotic activity (obtained by measuring areas under curves with a planimeter) increases rapidly as the dose is doubled. These data show that increased dosage markedly increases serum concentration and thus may enhance the drug's effectiveness.

FIGURE 6

Serum Levels With Varying Dosage



Antibiotic Activity With Varying Dosage



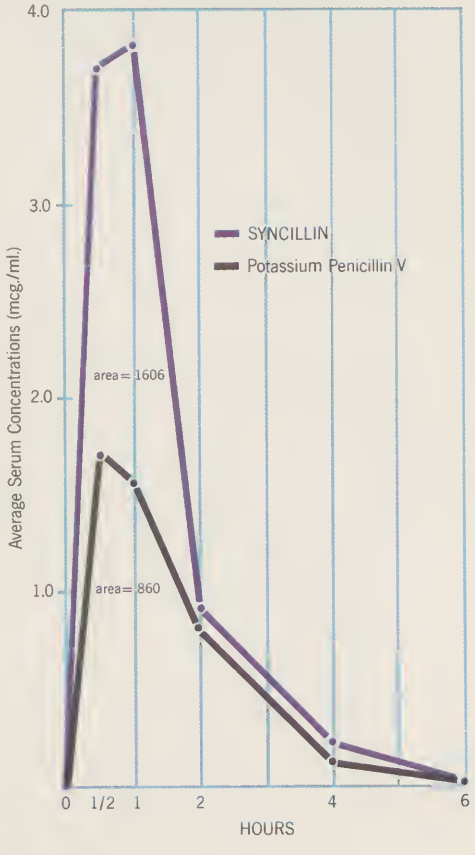
BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V AFTER ORAL ADMINISTRATION

Wright[6] performed comparative crossover blood level studies on volunteer subjects receiving equivalent amounts of potassium penicillin V and SYNCILLIN. The peak concentrations attained during the first hour after administration were twice as high with SYNCILLIN.

The total antibiotic activity as measured by the area under the curves (see Figure 7) indicates an almost 2 to 1 superiority of SYNCILLIN (1606) over potassium penicillin V (860).

The higher blood levels may be of value with organisms of only moderate penicillin-sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition these higher levels may be necessary where there is infection in areas with a poor blood supply.[7] Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue.

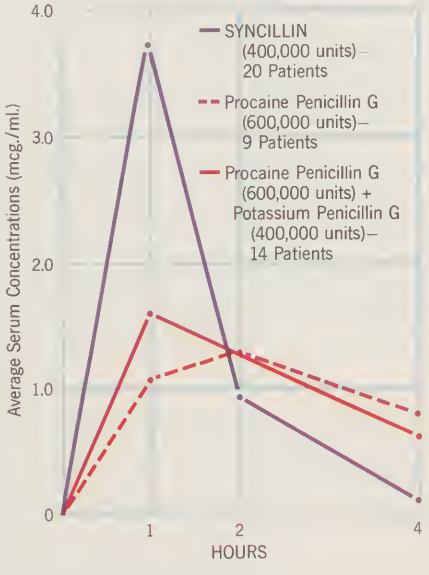
FIGURE 7
20 Subject Crossover
250 mg. Single Dose



BLOOD LEVELS MUCH HIGHER THAN WITH INTRAMUSCULAR PENICILLIN G

In addition, blood levels attained with oral SYNCILLIN[6] are much higher than those with intramuscular penicillin G.[8a, b] (See Figure 8.) Note that the level at one hour for SYNCILLIN (3.8 mcg./ml.) is more than twice as high as with procaine penicillin G, even when reinforced with potassium penicillin G (1.6 mcg./ml.). Since penicillins are *bactericidal,* these intermittent high serum levels can be clinically significant. Thus, SYNCILLIN offers the promise of superior efficacy via the safer oral route.

FIGURE 8—Serum Levels after Oral Administration of SYNCILLIN (250 mg.) and after Intramuscular Injection of Penicillin G



REDUCED HAZARD OF SERIOUS ALLERGENICITY BY SAFER ORAL ROUTE

SYNCILLIN has been administered in multiple doses to 437 patients and volunteers. One patient developed itching during therapy, possibly an allergic side effect. Another had a purpuric rash, but no relationship to SYNCILLIN was established. No reactions were observed in 9 patients with a known history of sensitivity to penicillin.

While the above data suggests the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *The usual precautions for oral penicillin therapy should be observed.* Patients with histories of asthma, hay fever, urticaria, or previous penicillin-sensitivity should especially be watched carefully. Since SYNCILLIN is administered orally, it may be expected to be safer than parenteral penicillin.

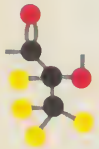
As Flippin[9] recently stated, "... it is well established that serious allergy to the drug [penicillin] is most likely to occur following parenteral administration, especially after repeated intramuscular injections; the oral route is least likely to initiate severe hypersensitivity reactions. This can be explained partly by the fact that when reactions develop following oral medication, they are usually slow enough to treat symptomatically; thus the progression of the reaction can usually be interrupted. . . . In view of the relatively high incidence of severe allergy to injectable penicillin, it would seem advisable to employ oral penicillin routinely, except in the control of infections involving the blood stream, endocardium, meninges, etc., in which cases the parenteral route remains the preferred treatment."

SYNCILLIN, like other penicillins, is essentially free of other toxicity. No hematopoietic, hepatic, or renal toxicity was observed in 210 volunteers receiving 1 gm. daily for 2 to 3 weeks.[10]

CLINICAL EFFICACY DEMONSTRATED IN PENICILLIN-SENSITIVE INFECTIONS

Clinical trials conducted by Blau and Kanof,[11] White,[12] Prigot,[13] Robinson,[14] Dube,[15] Ferguson,[16] Rutenburg,[17] Richardson,[18] Bunn,[19] Cronk,[5] Kligman,[10] and Yow [20] demonstrated the efficacy of SYNCILLIN in a variety of streptococcal, staphylococcal, pneumococcal, and gonococcal infections. Conditions treated included respiratory, skin, soft tissue, wound, and chronic urinary tract infections; acute gonorrhea; cellulitis; septicemia; otitis media; gingivitis; and Vincent's angina. In a few patients SYNCILLIN was used for rheumatic fever or gonorrheal prophylaxis.

One hundred seventy-two of one hundred ninety-six patients responded favorably to SYNCILLIN. The failures included 1 patient with pustular dermatoses, 10 elderly patients with chronic urinary tract infections, 1 patient with gonorrhea, 1 patient with a gram-negative infection, and 10 patients with staphylococcal infections. Lack of response of staphylococcal infections was attributed to the presence of resistant organisms or local suppurative foci requiring drainage.



Relatively few side effects were encountered. One patient experienced moderate itching of the skin which was controlled by an antihistamine. Another reported pruritus ani which did not interfere with therapy. Diarrhea occurred in 4 instances. There was one purpuric rash, but no relationship to SYNCILLIN could be established.

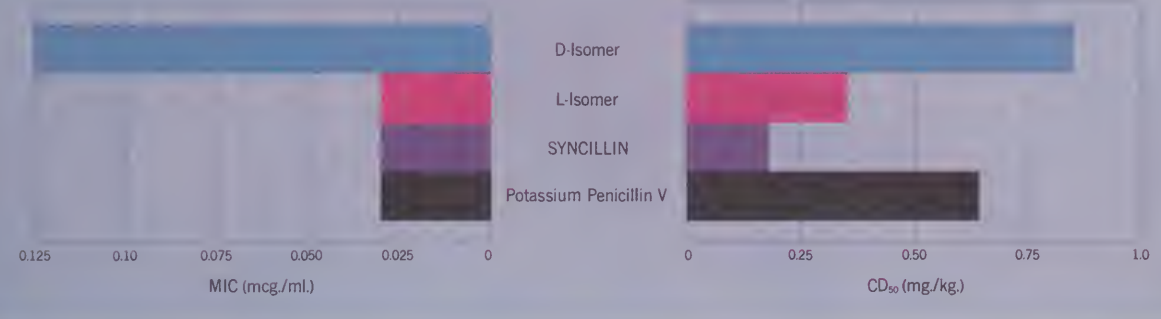
Clinical response usually begins within 24 hours in infections susceptible to SYNCILLIN. Recovery occurs in 4 to 7 days depending upon the severity of the infection. Gonorrheal infections respond very promptly to SYNCILLIN; 500 mg. b.i.d. for two days usually produce bacteriologic cures.

IMPROVED ANTIBIOTIC EFFECT FROM COMPLEMENTARY ACTION OF ISOMERS

SYNCILLIN is a mixture of isomers. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. Furthermore, the D- and L-isomers have other distinguishing chemical, pharmacological, and microbiological properties. Their *in vivo* and *in vitro* activities differ for many important pathogens. *Against many of the organisms tested, the combination of isomers* (SYNCILLIN) *is much more active than the stronger isomer alone.* This phenomenon of isomeric complementarity is not always demonstrable, for in a few instances SYNCILLIN is slightly less active.

Isomeric complementarity has previously been demonstrated *in vitro* (Figure 4) and *in vivo* (Figure 1). Figure 9 reveals a third form of superiority related to isomeric complementarity. Equal concentrations of SYNCILLIN and penicillin V were required to inhibit this growth of staphylococci *in vitro*. But, *in vivo*, a much smaller amount of SYNCILLIN *(one-third that of penicillin V)* was effective in an experimental infection with the same strain. These observations on complementary action indicated the advantage of producing the mixture of isomers as the medication to be made available for clinical therapy.

FIGURE 9 — Comparison of CD_{50} and MIC Values Against *Staphylococcus aureus* (var. Smith)



Isomeric complementarity has thus been demonstrated for:

—— *certain penicillin-susceptible streptococci, staphylococci and corynebacteria* in vitro *(Table 1)*

—— *penicillin-susceptible staphylococci* in vivo *(Figures 1 and 9)*

—— *penicillin-resistant staphylococci* in vitro *(Figure 4)*

—— *staphylococcal penicillinase antibiotic inactivation (Figure 5)*

Indications:

SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins.

SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage:

125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals.

Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions:

While present data suggest the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *Therefore the usual precautions with oral penicillin therapy must be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, the interval between dosages should be lengthened.

If superinfection occurs during therapy, appropriate measures should be taken.

Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply:

125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Lein, J.: Microbiology report to Bristol Laboratories Inc. 2. Wright, W. W.: Microbiology report to Bristol Laboratories Inc. 3. White, A. C.: Microbiology report to Bristol Laboratories Inc. 4. Dubos, R. J.: Bacterial and Mycotic Infections of Man, 3rd edition, Philadelphia, J. B. Lippincott Co., p. 690. 5. Cronk, G. A.: Clinical report to Bristol Laboratories Inc. 6. Wright, W. W.: Clinical report to Bristol Laboratories Inc. 7. Kass, E. H.: Am. J. Med. *18*:764 (May) 1955. 8a. White, A. C.; Couch, R. A.; Foster, F.; Calloway, J.; Hunter, W., and Knight, V.: in Welch, H. and Marti-Ibañez, F.: Antibiotics Annual — 1955-1956, Medical Encyclopedia, Inc., New York, 1956, p. 490. b. Data on file — at Bristol Laboratories. 9. Flippin, H. F.: Pennsylvania M. J. *62*:864 (June) 1959. 10. Kligman, A.: Clinical report to Bristol Laboratories Inc. 11. Blau, S., and Kanof, N.: Clinical report to Bristol Laboratories Inc. 12. White, A. C.: Clinical report to Bristol Laboratories Inc. 13. Prigot, A.: Clinical report to Bristol Laboratories Inc. 14. Robinson, C.: Clinical report to Bristol Laboratories Inc. 15. Dube, A. H.: Clinical report to Bristol Laboratories Inc. 16. Ferguson, B.: Clinical report to Bristol Laboratories Inc. 17. Rutenburg, A. M.: Clinical report to Bristol Laboratories Inc. 18. Richardson, J. H.: Clinical report to Bristol Laboratories Inc. 19. Bunn, P. A.: Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.: Clinical report to Bristol Laboratories Inc.

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Because of the infrequency of the disease in this age group, its sudden onset, the profusion of inconsistent presenting symptoms, and because the accompanying symptoms of anorexia and vomiting are also characteristic symptoms of many other ills of infancy.

*Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes *8*:289, 1959.

for those pediatric puzzlers..."A routine urinalysis and blood sugar should be done whenever the possibility of diagnosing diabetes is entertained."*

DIABETES MELLITUS AT AGES 1 TO 5

Order of Frequency of Presenting Symptoms in 110 Patients

Symptoms	No. of Patients	Per cent of total group
Polyuria	93	84.5
Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
Headache	1	0.9
Abdominal cramps	1	0.9

Adapted from Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.*

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KENTUCKY STATE MEDICAL ASSOCIATION
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MEDICUS

FEBRUARY 1960 • VOLUME 58 • NUMBER 2

Time after time... in study after study

Once again, controlled sensitivity studies have demonstrated the efficacy of CHLOROMYCETIN. In one long-term study,[1] designed to eliminate variable factors in patterns of bacterial resistance, 5,600 consecutive cultures of gram-positive organisms were tested over a 16-month period. Of the four broad-spectrum antibiotics evaluated, CHLOROMYCETIN was consistently superior.

Reports from the literature[2-8] have repeatedly confirmed the observation that CHLOROMYCETIN is effective against a wide variety of clinically important pathogens. The marked susceptibility of gram-negative as well as gram-positive organisms to CHLOROMYCETIN suggests this antibiotic as an agent of choice in many infections.[3]

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CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

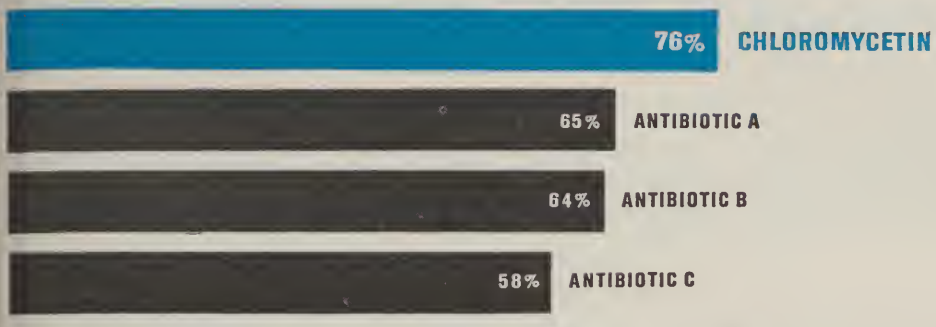
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REFERENCES: (1) Leming, B. H., Jr., & Flanigan, C., Jr., in Welch, H., & Marti-Ibãnez, F.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 414. (2) Goslings, W. R. O., & Buchli, K.: *Arch. Int. Med.* **102**:691, 1958. (3) Suter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* **9**:38, 1959. (4) Metzger, W. I., in Welch, H., & Marti-Ibãnez, F.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 966. (5) Fischer, H. G.: *Deutsche med. Wchnschr.* **84**:257, 1959. (6) Borchardt, K. A.: *Antibiotics & Chemother.* 8:564, 1958. (7) Schneierson, S. S.: *J. Mt. Sinai Hosp. New York* **25**:52, 1958. (8) Waisbren, B. A.: *Wisconsin M. J.* **57**:89, 1958.

*Adapted from Leming & Flanigan.[1]

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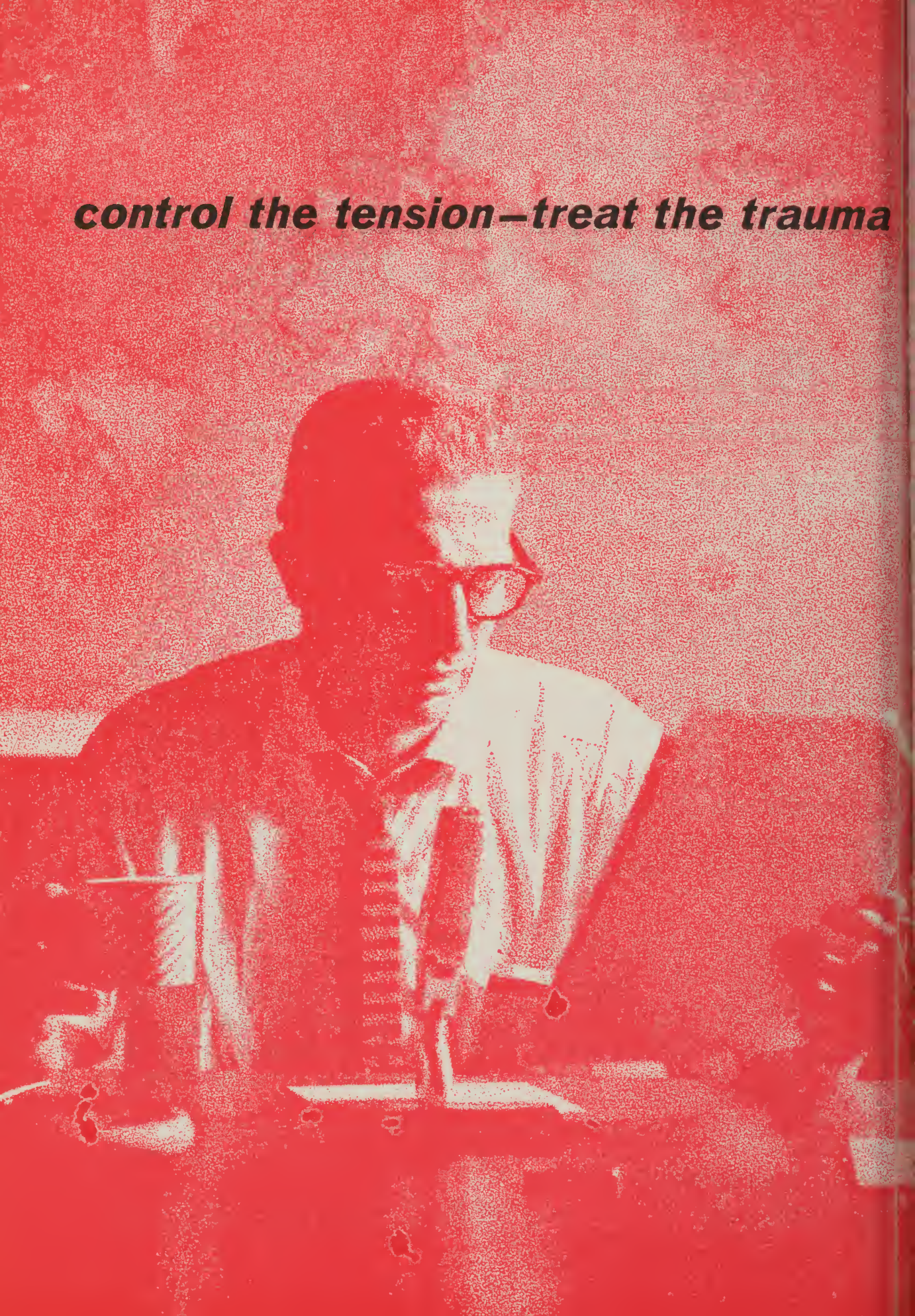
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MESSAGE FROM THE PRESIDENT

The Problem Of the Aging

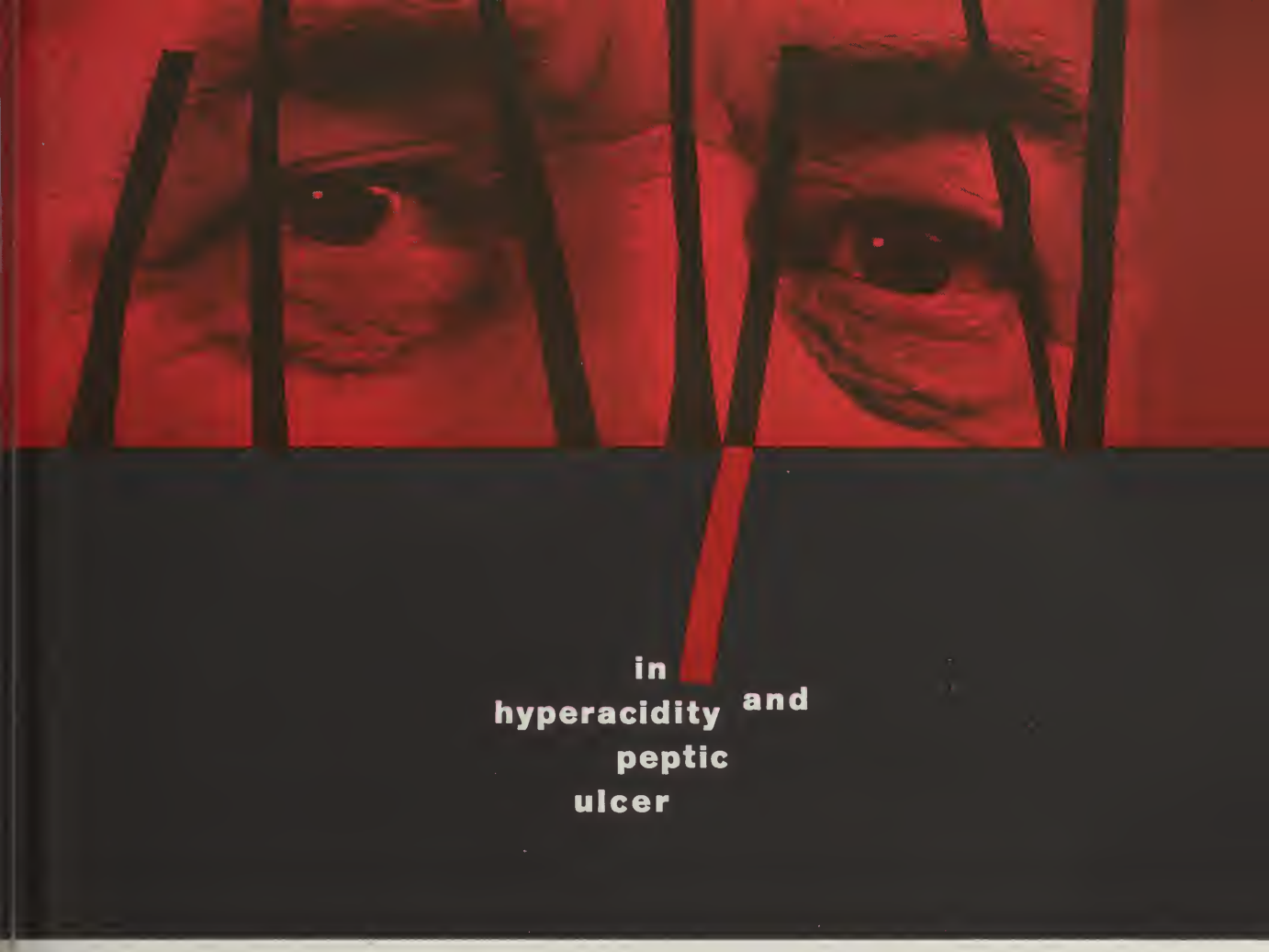
The problem of the aging might be described as the deteriorating of a machine. The medical profession and its allied groups have been tuning, repairing and refinishing these machines through the years, and today, with improved facilities, a superior armamentarium and perhaps a better appreciation of the machine by its owner, the machines are lasting longer. In these changing times we have a new group, our senior citizens, who like all the rest of us have their problems.

In 1900 there were only three million Americans aged 65 or older. Today, some sixteen million have achieved senior citizenship; and this includes some five million who are over 75 years of age. It is predicted that within the next decade this sixteen million will swell to almost twenty million, and that of this number some seven million will be 75 years or older.

Some fifty years ago no individual could reach a position of responsibility until he had been matured by the years. Once there, he was expected to serve on until incapacitated by the infirmities of age. Today, management and labor, and indeed the government, have combined to insure an individual's retirement at or about age 65. Few indeed are the people who, because of some particular knowledge, experience or judgment, can anticipate one or two additional years of service.

We need today to undertake a vast educational effort directed at the boys and girls who are in school now and will be tomorrow. We need to make clear that they have before them the possibility of many long years of splendid living, if they will only show some consideration for the future. A planned, voluntary retirement at age 65 with adequate funds has been found to be very acceptable to many people.

Louis Abell Jr.



in hyperacidity and peptic ulcer

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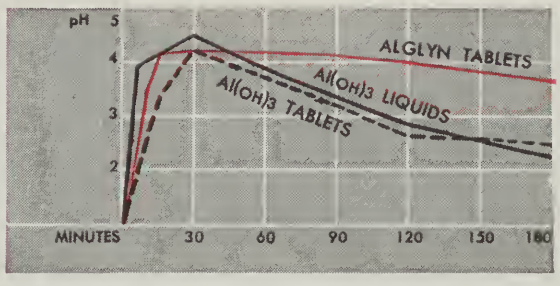
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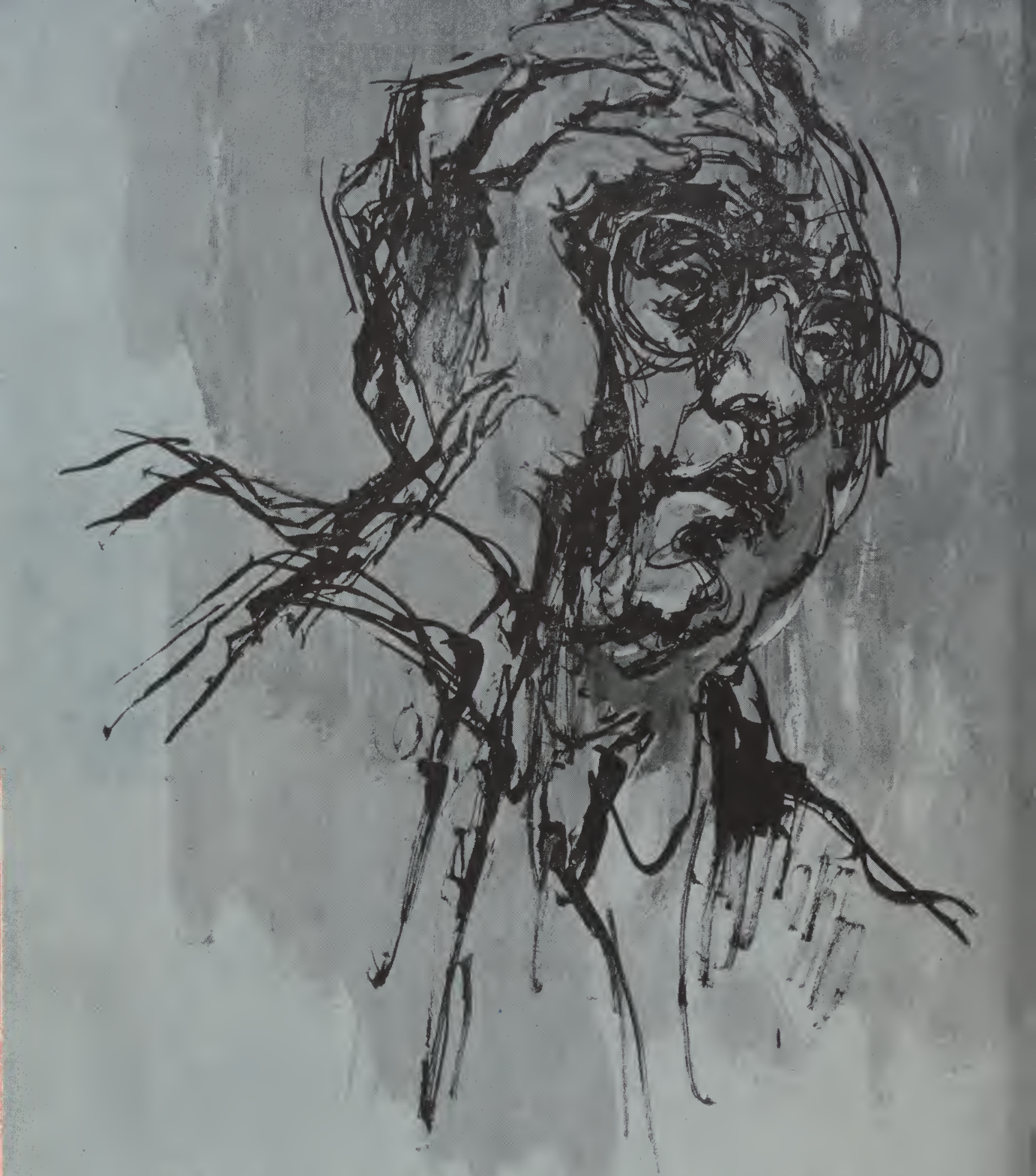
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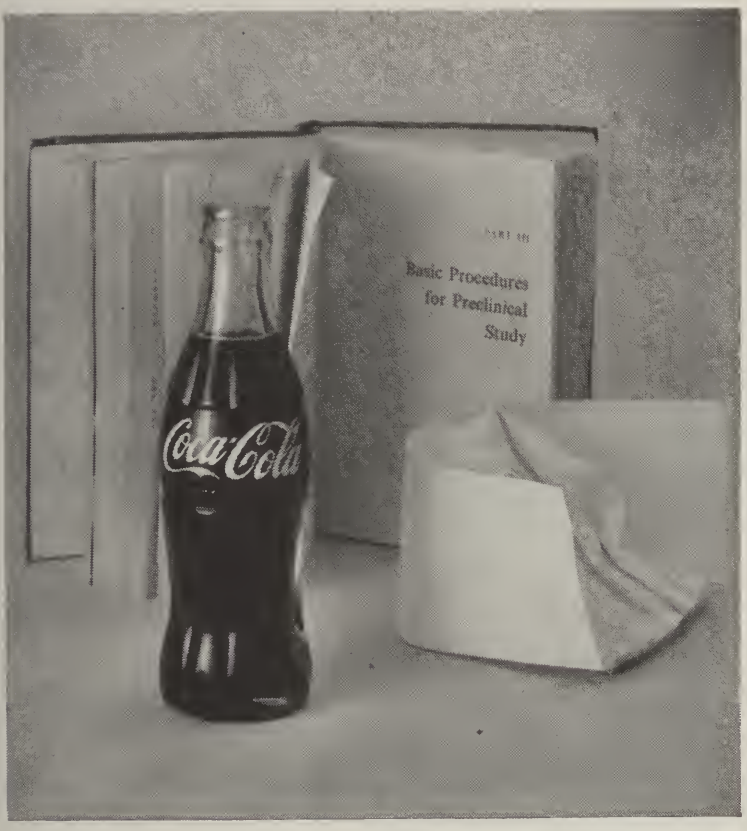
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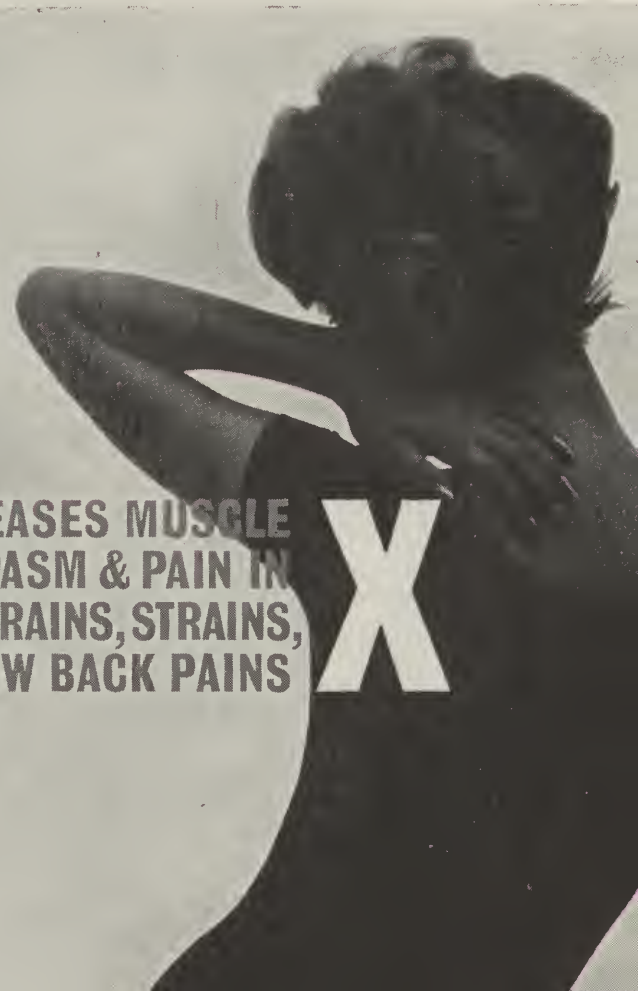
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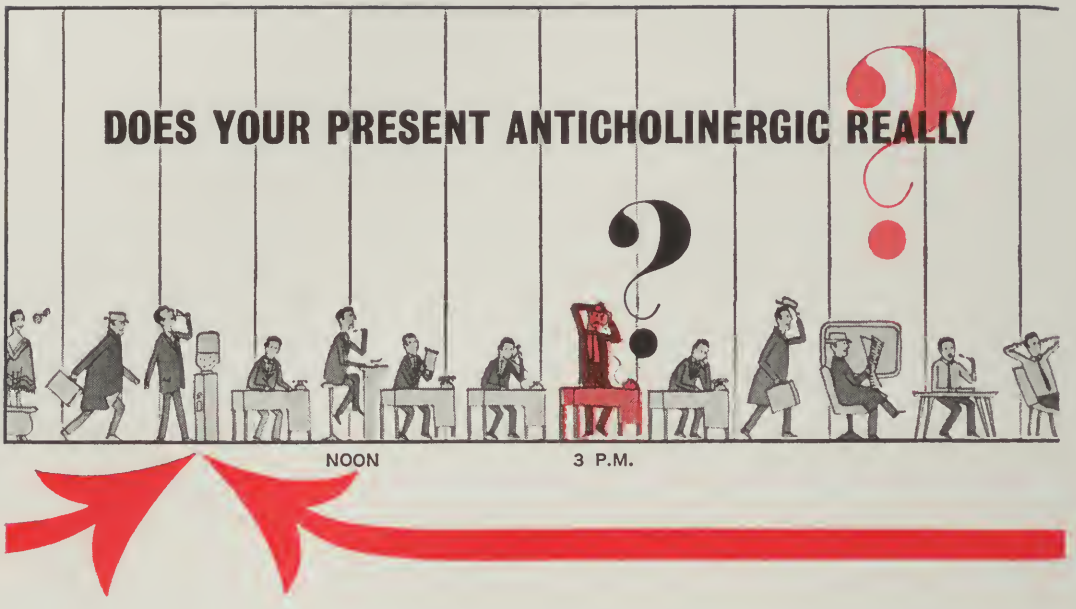
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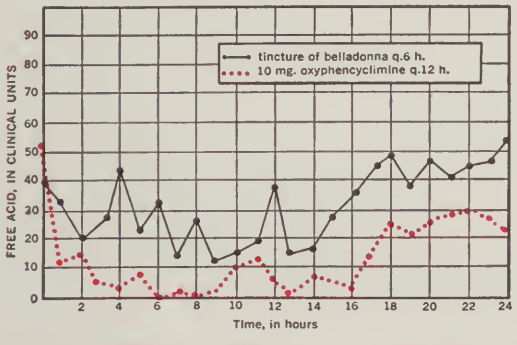
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Clinical Results: Effective in over 92% of cases.

As for Safety: "Side reactions were uncommon, usually no more than dryness of the mouth...."[4]

Each ENARAX tablet contains:

Oxyphencyclimine HCl ..... 10 mg.
Hydroxyzine (ATARAX®) ..... 25 mg.

Dosage: One-half to one tablet twice daily—preferably in the morning and before retiring. The maintenance dose should be adjusted according to therapeutic response. Use with caution in patients with prostatic hypertrophy and with ophthalmological supervision only in glaucoma.

Supplied: In bottles of 60 black-and-white scored tablets.

References: 1. McHardy, G., et al.: J. Louisiana M. Soc. 111:290 (Aug.) 1959. 2. Steigmann, F.: Study conducted at Cook County Hospital, Chicago, Illinois, in press. 3. Kemp, J. A.: Antibiotic Med. & Clin. Therapy 6:534 (Sept.) 1959. 4. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 5. Data in Roerig Medical Department files.

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THE INSURANCE PAGE



Voluntary Health Insurance and Physician's Fees

THE growth of voluntary health prepayment in the past two decades has been of incalculable value—both to the public, who must have the necessary health care, and to the physicians, who furnish this care. Through the mechanism of prepayment insurance, millions of Americans each year are able to take care of their hospital and doctor bills without going into debt or exhausting their reserves.

In purchasing such insurance, there are several objectives which the purchaser has in mind. Primarily, he wishes as much protection against the costs of illness as he can afford to pay for. Also, he wishes to budget the costs of the protection just as he budgets the cost of his other basic necessities. In the third place, he wants a feeling of assurance that his protection will be fairly adequate, and that it will not be just a token shield against the costs of illness.

From the viewpoint of the public, these objectives could perhaps be best attained through a "full coverage" type of protection, such as approximately 75 per cent of the Blue Shield Plans offer to those of their subscribers whose incomes are below certain specified levels.

In an indemnity type plan, such as Kentucky Physicians Mutual or such as the private insurance carriers offer, it is important that each subscriber be made to realize that only certain specified amounts are to be paid for any given service, and that payment in full for physicians' fees is not guaranteed. Misunderstanding occasionally arises because this point has not been made clear.

Of equal importance is the assurance to the subscriber that his physician will not use the insurance as a base on which to increase the usual charge for the service.

Any physician who would take the insurance allowance for a given service, and add to this his usual fee for the service, would not only be defeating the purpose for which the coverage was purchased but would, in fact, be guilty of an unethical and dishonest act. Such a practice, if it were widely followed, would cause a loss of public confidence, both in the voluntary health prepayment principle and in the integrity of the medical profession.

Fortunately, such abuses are extremely rare among our profession, if indeed they exist at all. It should be the responsibility of each of us, however, to make certain that none of our patients have any fear that their coverage will be so misused.

W. V. Pierce, M.D.



no irritating crystals[1] · uniform concentration in each drop[2]

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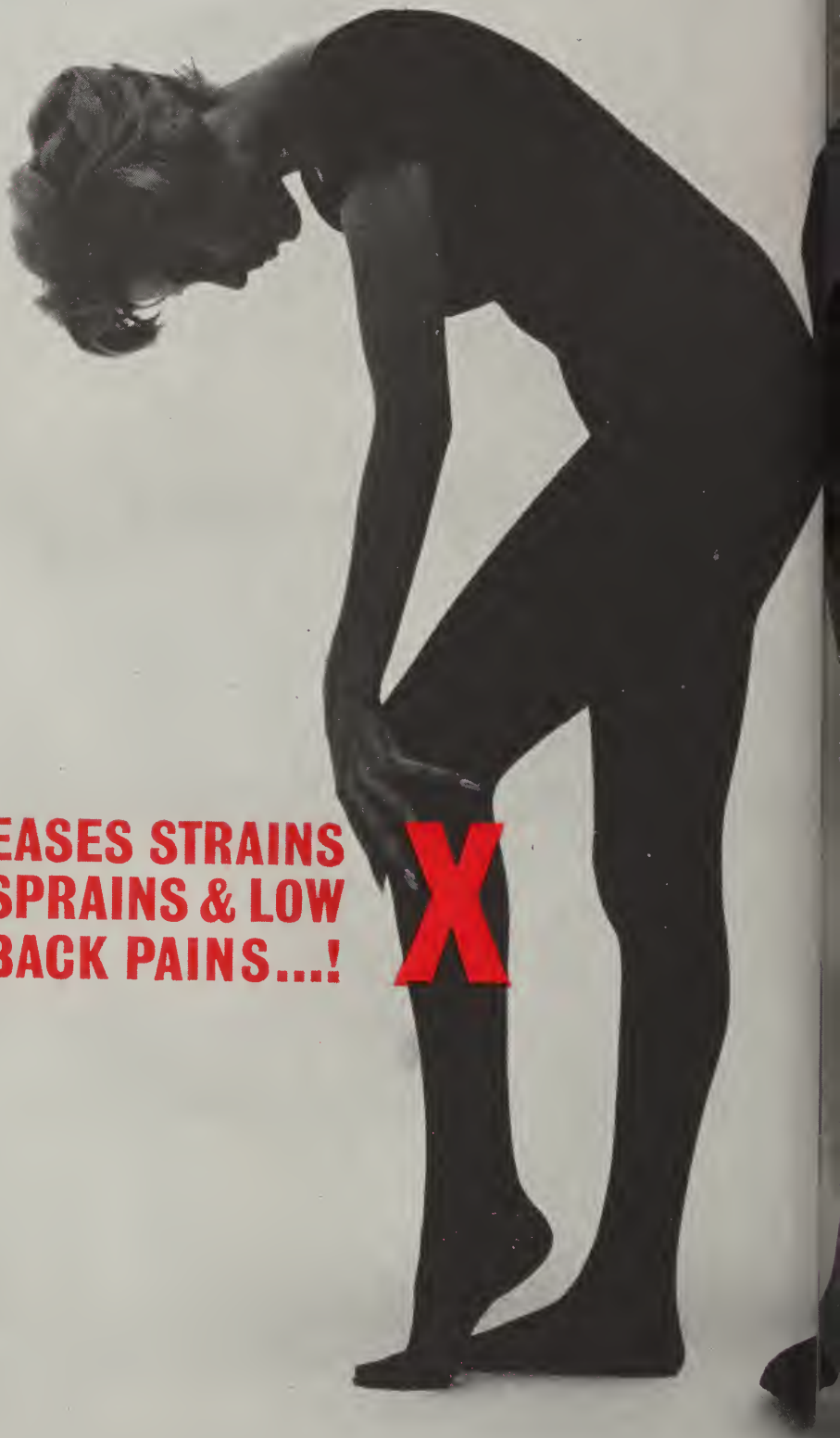
1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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Rela relaxes acute muscle spasm
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Rela provides a unique quality of persistent pain relief through its relaxant and analgesic actions
"Relief from pain was usually rapid and sometimes dramatic"[1]

Rela, through relaxation and analgesia, assures daytime ease and nighttime rest
"... A number of patients reported freedom from insomnia which they attributed to freedom from pain."[1]

indications: RELA is most beneficial in those conditions of the musculoskeletal system manifesting pain, stiffness and spasm.

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dosage: The usual adult dosage of RELA is one tablet 3 times daily and at bedtime. RELA has a rapid onset of action, with relief usually apparent within 30 minutes, and persisting for at least 6 hours.

supply: RELA is available as 350 mg., pink, coated tablets in bottles of 30.

1. Kuge, T.: To be published.

H-227

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WASHINGTON NEWS DIGEST



Washington, D.C.—Overshadowing all other developments from the standpoint of the medical profession was the flat prediction from a high Administration official and key lawmakers that Congress this year would vote some sort of liberalization of the Social Security program.

There was general agreement that Congress would broaden the Social Security plan for permanently and totally disabled persons by removing the requirement that a person has to be at least 50 years of age before receiving such benefits.

However, there were forecasts of even further liberalization. House Speaker Sam Rayburn (D., Texas) said monthly cash benefits also may be boosted. On the other hand, the House leader said he believed a majority of the House Ways and Means Committee was opposed to the disputed Forand bill that would finance partial health care for the elderly through higher Social Security taxes at an estimated extra cost of $2 billion annually. As a result, he said he did not think "there was a great deal of chance for it." But the AFL-CIO and some Congressional backers of the highly controversial bill were urging Congress to approve it this year.

* * *

Arthur S. Flemming, Secretary of Health, Education and Welfare, asserted that the Administration is planning to offer a program aimed at assisting needy aged to meet health bills, but gave no details. The official noted that the Administration has firmly opposed the Forand-type approach on grounds it would destroy the rapid progress in meeting the problem through private means. But Flemming, in a speech before the American Association of University Teachers of Insurance, said the Administration has an obligation "to stay with it" until it arrives at a plan.

Congress has extended the Social Security program every presidential election year since 1948, and 1960 appeared to be no exception. Whether or not the issue of medical care for the aged will be included was one of the big question marks early in the session.

* * *

Shortly before Congress convened, the Boards of Trustees of the AMA and the American Hospital Association, in a joint resolution, pledged to "mobilize their full resources to accelerate the development of adequately financed health care programs for needy persons—especially the aged needy—" at state and local levels.

The boards said Forand-type legislation is "not designed to assist the needy, since they apply to all Social Security beneficiaries and exclude the majority of needy persons who are not eligible for Social Security benefits."

Following the action, Louis M. Orr, M.D., AMA president, and three other AMA officials—E. Vincent Askey, M.D., AMA president-elect; F. J. L. Blasingame, M.D. executive vice-president, and Ernest B. Howard, M.D., assistant executive vice-president—visited Vice President Richard M. Nixon at his Washington Office. They told the Vice President that by the end of this year an estimated 60 per cent of the nation's aged persons who want and need voluntary health insurance will have it.

Mr. Nixon, according to the officials, was delighted to receive the information and "very much interested" in the program of voluntary health insurance for the aged.

* * *

Physicians who are officers of qualified clinics would be entitled to deduct as business expenses money set aside for their retirement under a proposed regulation of the Internal Revenue Service. The decision climaxed a five-year effort of a group of Montana physicians to secure such tax treatment, and marked an important tax development for physicians who operate clinics. Self-employed physicians continue to be barred from similar tax treatment, though there is legislation before the Senate Finance Committee that would afford them tax deferrals on funds set aside for retirement.

Synonyms for Pain Relief...

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Acetylsalicylic Acid . . . . gr. 3½
Caffeine . . . . . gr. ½
Codeine Phosphate . . . . gr. ½

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Caffeine . . . . . gr. ½
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IN
simple headache
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minor trauma
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minor surgery
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trauma
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relief of pain
of all degrees of
severity up to
that which
requires morphine

AND IN
fevers
dry,
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DONNAGEL: In each 30 cc. (1 fl. oz.):

Kaolin (90 gr.)	6.0 Gm.
Pectin (2 gr.)	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

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Same formula, plus

Neomycin sulfate ..... 300 mg.
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The first synthetic penicillin available for general clinical use

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BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V

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IMPROVED ANTIBIOTIC ACTION FROM ISOMERIC COMPLEMENTARITY





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ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSE

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MANY STAPH STRAINS MORE SENSITIVE TO SYNCILLIN IN VITRO

BRISTOL





FOR HIGHLY EFFECTIVE THERAPY OF THE LARGE VARIETY OF INFECTIONS CAUSED BY SUSCEPTIBLE PATHOGENS... NEW

SYNC

Significance of complementary action of isomers in SYNCILLIN

The antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than that of either of its two component isomers alone against many important pathogens, including some penicillin-resistant staphylococci. This phenomenon has been described as *Isomeric Complementarity*.

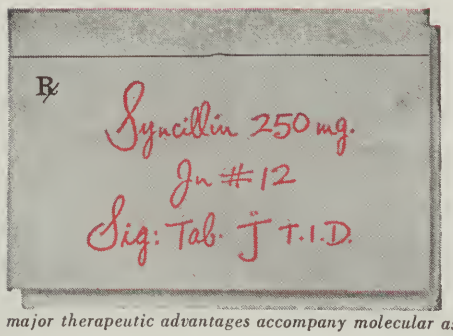
Significance of higher blood levels with SYNCILLIN

Higher blood levels may be of value with organisms of only moderate penicillin sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition, these higher levels may be necessary where there is infection in areas with a poor blood supply.[6] Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue. Also, antibiotic activity of SYNCILLIN is directly proportional to oral dosage. Increasing the dosage may, therefore, enhance the drug's effectiveness in certain cases.

Efficacy of SYNCILLIN against staphylococci and other resistant organisms

Studies have shown that SYNCILLIN is effective *in vitro* against 60 to 75% of hospital "staph" strains, while penicillin G and penicillin V are now effective against only 30 to 50%.[1, 2] Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN would be expected to be the most effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal[3] and gonococcal[4, 5] infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



major therapeutic advantages accompany molecular asymmetry

I L L I N™

Relation of intermittent high blood levels of SYNCILLIN to antibacterial efficacy

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations are sufficient to permit complete eradication of sensitive pathogens. Continuous high blood levels are not required with SYNCILLIN. According to Eagle,[7] "Soon after penicillin attains effective concentrations, the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective....The therapeutic significance of this postpenicillin recovery period is enhanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process *in vivo* continues for many hours after the drug itself has fallen to ineffective concentrations."

Reduced rate of inactivation of SYNCILLIN by staph penicillinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V and penicillin G. Penicillinase from *B. cereus* likewise inactivates SYNCILLIN less rapidly than penicillin V and G. But this would not impede the therapeutic use of this penicillinase in allergic reactions. This is because the massive dosage with which this enzyme is administered would effectively destroy SYNCILLIN in the body.

References: 1. Wright, W. W.: Microbiology Report to Bristol Laboratories Inc. 2. Kligman, A.; Morigi, E. M. E.; Wheatley, W. B., and Albright, H.: Paper presented at the Seventh Antibiotic Symposium, November 4-6, Washington, D.C. 3. Editorial: New England J. Med. **261**:305 (Aug. 6) 1959. 4. King, A.: Lancet **1**:651 (March 29) 1958. 5. Epstein, E.: J.A.M.A. **169**:1055 (March 7) 1959. 6. Kass, E. H.: Am. J. Med. **18**:764 (May) 1955. 7. Eagle, H.: J. Bact. **58**:475, 1949.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins. SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. *Therefore, the usual precautions for oral penicillin therapy should always be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals.
Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.
If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

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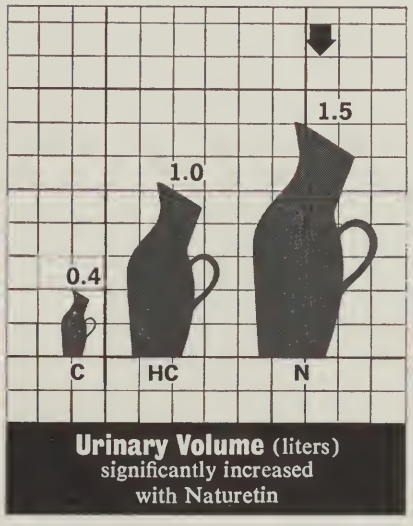
more closely approaches the ideal diuretic

Naturētin

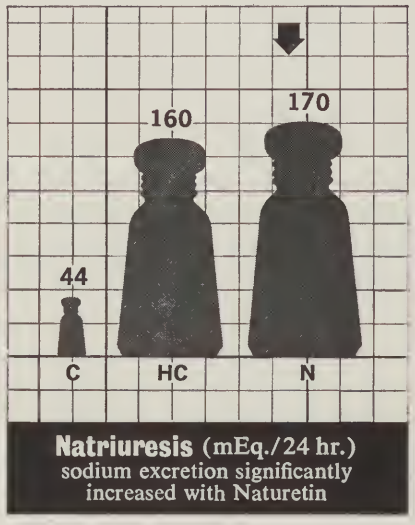
Squibb Benzydroflumethiazide

"When compared to other members of this heterocyclic group of compounds, this drug [NATURETIN] shows a significantly increased natriuresis and decreased loss of potassium and bicarbonate. In this respect it more closely approaches a natural or 'ideal diuretic.' It is effective upon continuous administration and causes no significant serum biochemical changes. It is effective in a wide variety of edematous and hypertensive states and represents a significant advance in diuretic therapy." *Ford, R.V., Pharmacological observations on a more potent benzothiadiazine diuretic; accepted for publication by the American Heart Journal.*

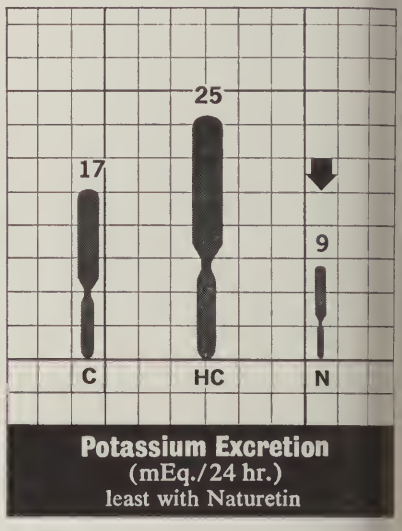
Comparison of electrolyte excretion pattern for the 24 hours following typical doses of chlorothiazide, hydrochlorothiazide, and Naturetin[1]



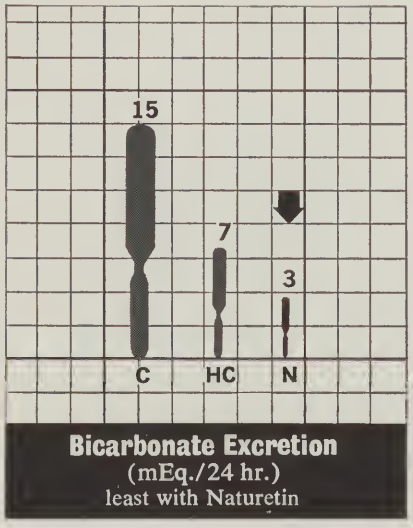
Urinary Volume (liters) significantly increased with Naturetin



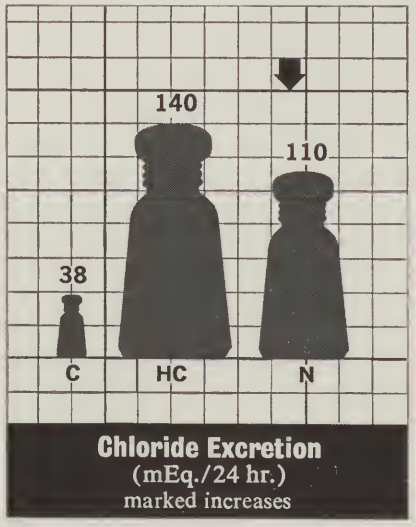
Natriuresis (mEq./24 hr.) sodium excretion significantly increased with Naturetin



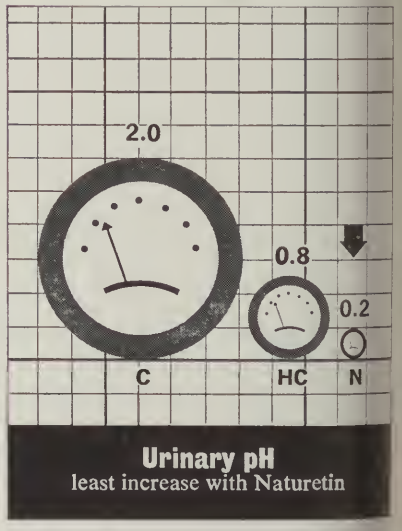
Potassium Excretion (mEq./24 hr.) least with Naturetin



Bicarbonate Excretion (mEq./24 hr.) least with Naturetin



Chloride Excretion (mEq./24 hr.) marked increases



Urinary pH least increase with Naturetin

Typical Doses: Chlorothiazide—1,000 mg.; Hydrochlorothiazide—50 mg.; Naturetin (Benzydroflumethiazide)—5 mg.

1. Adapted from: Ford, R. V., Squibb Clin. Res. Notes 2:1 (Dec.) 1959.

A single 5 mg. tablet once a day provides all these advantages[2]

- prolonged action — in excess of 18 hours
- convenient once-a-day dosage
- low daily dosage — more economical for the patient
- no significant alteration in normal electrolyte excretion pattern
- repetitively effective as a diuretic and antihypertensive
- greater potency mg. for mg.—more than 100 times as potent as chlorothiazide
- potency maintained with continued administration
- low toxicity — few side effects — low salt diets not necessary
- comparative studies with chlorothiazide, hydrochlorothiazide, and Naturetin disclose that smallest doses of Naturetin produce greater weight loss per day
- in hypertension, Naturetin, alone or in combination with other antihypertensives, produces significant decreases in mean blood pressure and other favorable clinical effects
- purpura and agranulocytosis not observed
- allergic reactions rarely observed

[2]Reports (1959) to the Squibb Institute for Medical Research.

Naturētin —*Indications:* in control of edema when diuresis is required, in congestive heart failure, in the premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs (certain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb Rauwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

Contraindications: none, except in complete renal shutdown.

Precautions: when Naturetin is added to an antihypertensive regimen including hydralazine, veratrum, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all preparations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous drop in blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin regimen . . . in hypochloremic alkalosis with or without hypokalemia . . . in cirrhotic patients or those on digitalis therapy when reductions in serum potassium are noted . . . in diabetic patients or those predisposed to diabetes . . . when increased uric acid concentrations are noted . . . when signs—leg or abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

Naturētin —*Dosage: in edema,* average dose, 5 mg., once daily, preferably in the morning; to initiate therapy, up to 20 mg., once daily or in divided doses; for maintenance, 2.5 to 5.0 mg., daily in a single dose. *In hypertension:* suggested initial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending on the individual response of the patient. When Naturetin is added to an antihypertensive regimen with other agents, lower maintenance doses of each drug should be used.

Naturētin —*Supplied:* tablets of 2.5 mg. and 5 mg. (scored)

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Preferably, antibiotic therapy should be based on pretreatment culture of the offending pathogen, but in bacterial pneumonia the problem may well be too pressing to permit the required delay of 24 to 48 hours. A differential diagnosis among bacterial pneumonias, based on such clinical grounds as speed of onset, sepsis and pain may guide the choice of antibiotic for initiation of therapy.

Should clinical judgment dictate that antibiotic therapy be started immediately, at the same time a sputum sample or a subglottic swab can be sent to the laboratory for culture and sensitivity studies. If the response to the first antimicrobial agent proves unsatisfactory, a reasonable basis for changing therapy will then be at hand.

Choosing the Antibiotic

Since therapy must be started at once for bacterial pneumonia, it is advisable to choose a broad-spectrum antibiotic that quickly produces high levels of active agent (e.g., tetracycline phosphate complex, TETREX). Such an antibiotic probably has the best chance of controlling the pathogen, whether it be gram-negative or gram-positive. And if the laboratory report shows that the invading organism is much less sensitive to tetracycline than to other agents, the patient can then be changed to an appropriate antibiotic. If the difference in sensitivity is slight, then the possibility of side effects, sensitization, and toxicity should be evaluated before changing therapy to another antibiotic.

The greatest number of bacterial pneumonias are caused by pneumococci, which respond very well to penicillin, tetracycline, and chloramphenicol. Also, these antibiotics are usually effective against the other gram-positive coccal pneumonias. But penicillin is ineffective against the viral pneumonias and the gram-negative *Hemophilus influenzae* and *Klebsiella pneumoniae*. Although *K. pneumoniae* causes only about 1 to 2 per cent of pneumonia cases on the average,[1] these are apt to be acute and fulminating (Friedländer's pneumonia), with a high mortality rate if not effectively treated. Since pneumococcal pneumonia may be difficult to distinguish clinically from Friedländer's, except by gram-stained sputum smear, it may be wiser to start treatment with an agent also effective against Klebsiella.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reaction. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

Tetracycline is also clinically effective in primary atypical pneumonia.[3]

The tetracyclines (e.g., TETREX) have the advantage of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

No one would deny that appropriate antibiotic therapy has greatly reduced morbidity and saved many lives of patients with bacterial pneumonia. Nevertheless, general supportive measures in the care of patients remain important even today. Especially in the desperately ill patient, antibiotics are not considered as substitutes for the individual evaluation, clinical observation and judgment of the physician.

Some Micro-organisms Susceptible*[a] *to Tetracycline (TETREX)[b]

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; *C. diphtheriae; B. anthracis; E. coli;* Proteus; *A. aerogenes; Ps. aeruginosa; K. pneumoniae;* Shigella; Brucella; *P. tularensis; H. influenzae; T. pallidum;* Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; *E. histolytica; D. granulomatosis.*

a Some strains are not susceptible.

b Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics. 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

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1. Smith, I. M., and Soderstrom, W. H.: J. A. M. A., *170*:184 (May 9), 1959.

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Thyroid Cancer And The Solitary Thyroid Nodule*

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Thyroid cancer, an uncommon but not rare condition, usually begins in a single area often detectable as a solitary, nondescript lump, but diagnosed with certainty only by surgical biopsy

THYROID cancer is an uncommon, though not rare, condition occurring in a ratio of about 25 cases per million population yearly in the United States.[1] There are, of course, regional variations, and it has been both asserted and denied that thyroid cancer occurs more frequently in goitrous regions.[2] Statistically, it appears that cancer of the thyroid gland is definitely on the increase, especially in children, and especially during the past ten years.[2,3] Thyroid cancer occurs at all ages, predominantly in females, though often enough in males, with a sex ratio of more than two to one in favor of the female. Most of the cases reported occur before the age of 50.

Classification

No essay on thyroid cancer would be complete without a pathologic classification of the types encountered, and their clinical characteristics. The simplest and the best, which has the endorsement of today's foremost thyroid pathologists, is given below.[4]

TABLE I

1. Differentiated
- A. Papillary
- B. Follicular

2. Undifferentiated
- A. Small cell
- B. Giant cell

By and large, the differentiated types are well behaved and lend themselves to long remissions and long-term survivals after a variety of therapeutic assaults. However, rapid growth, metastasis and death are seen in this group, though infrequently. Conversely, the undifferentiated types are the bad actors. Early and widespread metastasis and death is the rule, despite heroic therapeutic efforts although, here again, long-term survivals occasionally occur.

Present thinking holds that most, if not all, thyroid cancers begin with a single area or focus in the thyroid gland, often detectable as a solitary lump or nodule.[5] The corollary to this is

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that if thyroid cancer is apprehended and vigorously dealt with by radical surgery at this early stage in its career, it will be found more highly curable.

It would appear, then, that it is highly desirable to follow a program of surgical excision of *every* solitary thyroid nodule, in order to detect, and treat vigorously and efficiently, thyroid cancer in its early stages. It has been our experience, however, that, while it is easy to urge surgical exploration of the neck in males, especially the older and scrawnier types, an emotional block plagues the physician confronted with a solitary thyroid nodule in a child or in the unblemished neck of a young attractive female. This not infrequently introduces an unwarrantable degree of emotional non-objectivity into medical advice. Unfortunately this emotional bias can be, and too often is, readily rationalized by resort to the current literature on thyroid cancer in which one can invariably find support for any view or tactic one wishes to adopt. This situation is so confused that even an objective professional discussion is likely to lose sight of certain fundamental truths.

An Illustration of the Problem

In an effort to restore practical common sense to the question of what to do about the solitary thyroid nodule, let us disregard percentages, statistics and shades of opinion, and imagine a conversation between a well-informed physician and his patient, an intelligent and informed woman of about 35 with a solitary thyroid nodule.

PATIENT—"Well, Dr. . . . ., I am happy to know that my annual checkup has shown no signs of serious illness or of cancer."

PHYSICIAN—"Yes, Mrs. . . . ., but you do have a small lump in your thyroid gland that I am concerned about and I want you to have it taken out."

PATIENT—" 'Taken out'—You mean by an operation, Dr. . . . .? I thought you said I was perfectly well."

PHYSICIAN—"You are perfectly well. This lump may be harmless, or it might be a small thyroid cancer."

PATIENT—"But I thought you said you found no evidence of cancer."

PHYSICIAN—"That is correct. This little lump shows none of the signs of cancer, yet it might be one nevertheless."

PATIENT—"Do you think it likely that it is a cancer, Dr. . . . .?"

PHYSICIAN — "No, Mrs. . . . ., thyroid cancer is not common, and I do not think that it is very likely that this lump is a cancer, purely on the basis of percentages."

PATIENT—"Then, why must I have an operation to have it taken out? Can't you tell whether or not it is cancer some other way? It has been there almost a year without growing, doesn't that mean that it isn't a cancer?"

PHYSICIAN—"No, Mrs. . . . ., that doesn't rule out thyroid cancer. Even if it had been there unchanged for three or four years we would still not be sure. Even now if we watch this little lump and it does not grow, but even reduces a little in size, we cannot be sure that it is not a small papillary cancer of the thyroid gland."

PATIENT—"I have heard that cancers are very hard and fixed. This lump is soft and movable. Doesn't that mean that it is benign?"

PHYSICIAN—"Unfortunately not. Thyroid cancer is often soft and freely movable at first."

PATIENT—"But I am a relatively young woman, Dr. . . . . I thought cancer afflicted old people."

PHYSICIAN—"Thyroid cancer arises in young people, especially women, more commonly than in the aged. In this respect it differs somewhat from the more common forms of cancer."

PATIENT—"Isn't there some test you can do to prove whether this lump is cancer or not without an operation? Can't you give me thyroid extract and if it shrinks or disappears, won't that prove it isn't cancer?"

PHYSICIAN—"I'm sorry, but it won't. The most common forms of thyroid cancer will also shrink down and may disappear under thyroid extract treatment. As for any laboratory test for thyroid cancer, there is none that I know of that is at all reliable. Even radio-iodine, which you have heard about and from which we have had great hopes in this respect, is practically worthless when it comes to deciding whether a solitary lump like yours is cancer or not."

PATIENT—"But must I have an operation? Can't you put a needle in the lump here in the office, and suck some cells out, and look at them under the microscope and tell whether it is cancer or not?"

PHYSICIAN—"We might, but there are objections to this method. It would be painful and unpleasant. I might hit a vessel with the needle and cause a hemorrhage. I might not get enough material out to make an accurate diagnosis. Even under the best circumstances the method is open to error and the accuracy of diagnosis leaves something to be desired. The very best way, and practically the *only* way to be one hundred per cent sure, is to cut out a little piece of the lump and put it under the microscope. That can only be accomplished by a surgical operation done in the hospital."

PATIENT—"Won't that be painful? Won't I be sick in the hospital for quite awhile? Isn't it dangerous?"

PHYSICIAN—"The answer is 'no' to all three questions. You will be asleep during the operation so you will feel no pain. Afterwards, there will be very little soreness and for a few days only. You should be able to leave the hospital in two or three days depending on how much has to be done. In addition, the procedure is definitely not dangerous."

PATIENT—"Then, if I understand you correctly, Dr. . . . ., you are telling me that *there is no way at all, even for the wisest and most experienced doctor,* to tell whether a simple lump like this one of mine is or is not a thyroid cancer unless it is cut out and looked at under microscope. Is that correct?"

PHYSICIAN—"Yes, Mrs. . . . . You are absolutely correct."

Facts and Fancy

This relatively simple approach to the problem becomes complicated by the following mixture of fact, emotion and fancy, which can be found with little or no trouble in the voluminous current literature on thyroid cancer.

1. "Thyroid cancer is like a pimple—leave it alone and it will go away and not bother you—squeeze it or surgically traumatize it and it will spread and kill you."

   The true facts are that thyroid cancer kills one out of four persons afflicted with it. There is no evidence that proper surgery accelerates the growth of, or the spread of, thyroid cancer.

2. "Thyroid cancer can be controlled indefinitely by irradiation and thyroid hormones without the necessity of a surgical operation."

   The truth is that less than half of the thyroid cancers are controllable, less than 10 per cent take up radio-iodine, and the length of remission of the controllable types varies so much as to be unpredictable.

3. "Radical neck surgery, more often than not, is mutilating and often fails to eradicate the thyroid cancer."

   Actually radical neck surgery skillfully performed is not mutilating or deforming. Frequent failure to eradicate cancer is a characteristic of all types of radical surgery for malignant disease, yet it is balanced by successful and complete extirpation in equal degree. No other form of treatment can do as well.

4. "If the thyroid nodule is a lethal cancer, it cannot be eradicated by surgery at *any* stage. If it is not a lethal cancer, it can be controlled just as well by conservative measures as by radical surgery."

   Not so. Lethal thyroid cancer can be, and frequently is, eradicated completely and permanently if dealt with early.

On the other hand, thyroid cancer, not eradicated or treated surgically, even if controlled for long periods by conservative measure, eventually kills one out of four. Furthermore, surgery, properly conceived and carried out fully, offers to the patient the only chance of complete eradication and permanent cure of thyroid cancer. Less complete and more conservative measures, embodying non-surgical treatment, combinations of limited surgery, hormones and irradiation, do not offer the patient any more than a possibly amicable co-existence with cancer. If an earnest attempt at complete surgical extirpation fails, the possibility of control-

led co-existence with cancer is still left open to the patient. Under these circumstances, the thyroid cancer may be controlled from then on (if it is a controllable type) by means of conservative measures employing irradiation and hormones, with apparently better chance of success than if the primary tumor and its immediate extensions had been left in place. It is doubtful whether a patient, honestly and clearly offered the choice between the possibility of complete removal of his cancer and the gamble of controlled co-existence with it, would voluntarily choose the latter.

Proper Treatment

Having surmounted the emotional, semantic and philosophical obstacles to surgical investigation and treatment of the solitary thyroid nodule, the physician and his patient are beset by two more questions:

1. **How to Go About Getting the Lump Out**
2. **What to Do If Cancer Is Found**

The answer to (1) is that the lump or nodule must be completely removed in a manner that avoids cutting into or across any possible invisible extensions of the process. This means total lobectomy, if the nodule is laterally placed; wide isthmectomy, if centrally located; or isthmectomy and homo-lateral lobectomy, if eccentrically located in the isthmus.

If cancer is found at the operating table, either by gross recognition or by frozen section, the thyroid resection previously described must be complemented by a radical neck dissection on the homo-lateral side. This is so, even if no palpably enlarged nodes are found, because it is well established by now that microscopic cancer will be found in the neck nodes sufficiently frequently in these cases to warrant neck dissection in all.

If cancer is verified in one hemithyroid and the opposite lobe is nodular, it too should be removed, constituting a total or near-total thyroidectomy, because of the very real possibility of foci of cancer in the opposite lobe.

In centrally placed cancers, total thyroidectomy and bilateral neck dissection, in two stages, should ideally be done. The choice of which side of the neck to do first may be determined by the location of enlarged nodes. If there are no palpable nodes, and the central lesion is a papillary type, neck dissection may be postponed with propriety indefinitely.[6]

In any neck dissection for thyroid cancer, special attention should be paid to removal of the tracheal-esophageal, retro-esophageal, and infrathyroid lymph nodes. If the latter are involved by cancer, upper mediastinal dissection through the neck incision is justifiable. If cancer is grossly recognizable here, the sternum should be split and a formal mediastinal dissection should be done. If a staged bilateral neck dissection is planned, mediastinal dissection should accompany the second stage.

Summary

As in the Declaration of Independence, "We hold these truths to be self-evident," about thyroid cancer.

1. Thyroid cancer kills people (one out of four) and when found early should be as completely removed as possible, *at the first operation.*
2. The nondescript early thyroid cancer has no distinguishing qualities, which set it apart clinically or by any known test from a benign lump, except by microscopic examination of tissue.
3. *Any* solitary thyroid lump could be a cancer.
4. Every solitary thyroid lump should be surgically removed for microscopic examination.
5. A logical, planned, thoroughly-executed attempt at surgical extirpation of thyroid cancer is preferable to deliberate planned co-existence with cancer.
6. The approved methods of removing thyroid lumps for examination have been described.
7. What to do surgically if the thyroid lump is cancer has been outlined.

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Pedodontics Grows Up: The Science Of Dentistry For Children*

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During the last 32 years, pedodontists have developed techniques which can now be applied to the treatment of children with cleft palate, mental retardation and cerebral palsy

THERE are two special fields of dentistry which deal with the problems of children. The specialty of orthodontics is well known and has to do with the diagnosis and treatment of malocclusions. The specialty of pedodontics is of much more recent development and its field of endeavor is the broad one of Dentistry for Children.

History

From the organizational standpoint, Dentistry for Children, as a special branch of dentistry, dates from about 1927 with the formation of the American Society for the Promotion of Dentistry for Children. This organization was an outgrowth of the Section on Pedodontics of the Detroit Clinic Club, and it exists now as the American Society of Dentistry for Children, with a membership of approximately 4,200. The emphasis of this organization is still somewhat "promotional" in nature, in that membership is open to any dentist "interested in" dentistry for children.

Recognition of the practice of the specialty of pedodontics occurred in 1941, when the American Board of Pedodontics was incorporated in the State of Michigan. War restrictions prevented any activity of the Board until 1949, when the first examination was given.

The formal organization of the specialty of pedodontics on a national basis occurred in 1947 with the organizational meeting of the American Academy of Pedodontics in Ann Arbor, Michigan. Membership, now about 90, is limited to dentists whose vocation is directly concerned with Dentistry for Children on a full-time basis.

These developments are a far cry from the early days when children were cared for in the dental office in order to maintain the good will of the rest of the family. There were a few hardy souls, several of them being women, who limited their practices, and they were considered to have no small amount of temerity. Their service consisted mainly of the repair of dental caries and its sequelae, and in those days that job was a big one. For that matter, it still is, but some daylight is now visible.

Fluoridation

A change in practice is slowly occurring, brought about by the addition of fluoride to drinking water. This change is gradual and probably will never be total in the sense that dental caries will not occur. The most recent figures on caries incidence for the City of Louisville indicates that there has been a reduction of decay of 53.2% for elementary school children. These figures cover the period from August, 1951, when fluoride was added to the drinking water of Louisville, through the school year 1958-59.

At the University of Louisville, School of Dentistry, Children's Clinic, children used to

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present with large deep cavities in all the posterior teeth and many in their anteriors. Now, children are seen regularly with no caries in the anteriors and only a few small cavities in their posterior teeth. Formerly, our students had no difficulty at all in fulfilling their graduation requirements in the field of pulp operations; now they encounter great difficulty in doing so. Formerly, it was difficult to teach ideal cavity preparation because there were so few ideal cavities to prepare; now, the great majority of cavities are ideal.

Changes in Teaching

And so the teaching program at the University of Louisville, School of Dentistry, in pedodontics has had to change. More emphasis can now be placed on teaching our postgraduate students the principles of normal growth and development of the child's jaws and teeth. The necessity for this instruction was always present; but the student's attention used to be distracted by the magnitude of the caries problem.

Now it will be possible to broaden the horizon of the dental care of children to include better supervision of the development of the child's dentition and occlusion. Our students can now be taught how to make a diagnosis of gross discrepancy between jaw size and total tooth size, and thus indicate a treatment plan involving the serial extraction of certain teeth, so that the remaining teeth can reposition themselves in the jaws. To a certain extent, the earlier this diagnosis can be made the better, since later full-scale orthodontic treatment may be avoided or simplified.

Our students can be taught how to treat some of the simpler orthodontic problems. The guidance of a tooth which is erupting in crossbite can be quite routinely managed by our graduates. The management of ectopic eruption of a permanent first molar can be treated during its erupting phase at 6 years of age, rather than waiting until the child is an adolescent and referring to the orthodontist a much more complicated and difficult case.

Problems of persistent habits, developmental anomalies, such as supernumerary teeth and congenitally absent teeth, and ankylosis are among those whose diagnosis and treatment our students are now competent to make and carry out.

The treatment problem of the child with cleft palate is another area where pedodontists have been able to fit in well. While regional philosophies differ, and treatment programs vary in different parts of the country, sufficient experience is being gained so that end results are quite satisfactory.

Two precepts seem to be well established in the managing of these cleft cases. The first is that a child who has such a handicap must be managed by a team, an integrated group, who have an earnest interest in the future habilitation of the patient. The second precept is that the treatment program is a long-range one and extends throughout the developmental period.

There are periods when intensive treatment by several different members of the team needs to be rendered. These periods then alternate with periods when the child is permitted to consolidate his gains by normal growth. Throughout the whole treatment time, the pedodontist must maintain regular surveillance, so that oral health may be maintained.

Other Progress

During the past 10 years, the pedodontist has also made definite progress in the oral care of children with cerebral palsy. Quite in contrast to the cleft palate child, who has a very unusual oral problem, the cerebral palsied child presents a rather ordinary oral condition, the treatment of which constitutes the special problem. However, the use of general anesthesia and the development of definite operating room techniques and facilities have brought oral rehabilitation to many who otherwise would be dentally crippled. The use of modern sedative, hypnotic and/or tranquillizing drugs oftentimes has made it possible to manage some cerebral palsied children in the dental office.

These and other imaginative techniques have permitted progress to be made in the dental treatment of children who have rheumatic or congenital hearts, ectodermal dysplasia, cleidocranial dysostosis, or mental deficiency. Each of these cases is challenging and their successful treatment by pedodontists attests to the broad postgraduate training and resourcefulness of these dental specialists.

Expected Developments

For the future, some areas of expansion of treatment are foreseeable soon:

A. A rapid expansion of palliative, preventive and interceptive orthodontic treatment should soon be apparent. Better diagnosis of incipient stages will surely lead to earlier treatment which in turn should be simpler, shorter and more economical.

B. An expansion of the use of cephalometric radiography as a diagnostic tool. Training in this diagnostic technique is not as yet readily available, but demands by those who include children in their practices will have to be met.

C. An approach to the development of a better psychological attitude by future generations is foreseen. There is beginning to be an awakening of interest in the factors which influence the child's behavior in the dental office. Experience is being gained in the use of drugs to affect his emotional reaction. The effect of hypnosis in this environment may prove to be most valuable.

D. Recent developments in equipment, especially that used in the preparation of cavities, has greatly speeded up the procedure and has eliminated the terror with which patients have traditionally approached dental treatment. Increased rotation speeds of the dental engine have allowed a greatly reduced pressure to be placed on the handpiece so that now merely the weight of the handpiece itself (4 ozs.) is sufficient to do the cutting. There has been a redesign of the burs and a great increase in the use of diamond grinding points and stones which speeds up the cutting efficiency. And finally, the use of water as a coolant prevents the increase in temperature which formerly was the greatest source of pain during cavity preparation.

E. Research in the etiology of congenital malformations and deformities may lead to much better treatment of them.

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Paroxysmal Atrial Tachycardia With Block

W. P. Hall, M.D.,
Paducah, Ky.
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This rhythm disturbance has a distinctive form, its identification is of vital importance since its occurrence is not infrequent, and its prompt treatment may be life saving

THE purpose of this paper is to present the clinical and electrocardiographic features of paroxysmal atrial tachycardia with block (P.A.T. with block). Electrocardiograms of 10 patients we have observed will be used to demonstrate these features.

This rhythm disturbance has a distinctive form and its identification is of vital importance since it may occur not infrequently during the course of digitalis therapy as well as independently. Its recognition and prompt treatment may be life saving.

At the outset it must be emphasized that irrespective of the similarity of name, this rhythm disturbance is not the well-known common classical paroxysmal auricular tachycardia. In spite of some similarities it is an entirely different condition. Because it has some features of both paroxysmal auricular tachycardia and flutter, it has been called atrial hybrid arrhythmia.

Paroxysmal atrial tachycardia with block is neither rare nor a recent discovery. In 1909, Sir Thomas Lewis[1] presented graphic evidence of this arrhythmia by means of polygraphic tracings. A year later, Sir James McKenzie[2] obtained a polygraph demonstrating P.A.T. with block. The relationship between digitalis and P.A.T. with block has been considered almost from its discovery. In 1932, Heyl[3] produced P.A.T. with block on nine separate occasions in the same patient by giving digitalis.

The first study reporting more than a few cases was done in 1943, when Dechard, Hermann and Schwab[4] reported 40 patients with P.A.T. with block, all but seven having had digitalis. In this same year, Barker, Wilson, et. al.[5] reported 18 cases of P.A.T. with block and felt that large doses of digitalis might restore normal rhythm. Until recent years P.A.T. with block has been considered a rare and unusual disorder of questionable etiology. Recently, with the work of Levine and Lown,[6] it has been shown to be relatively common and its recognition important in order that proper therapy be instituted.

Occurrence & Classification

P.A.T. with block may occur under a wide variety of circumstances but, generally speaking, cases can be divided into two categories, namely a) those unrelated to digitalis and b) those related to digitalis administration.

Cases not related to digitalis occur in patients without other evidence of heart disease as well as in patients with advanced heart disease. An example occurring in a patient without evident heart disease and of 25 years duration has been reported.[7] Lown and Levine[8] feel such idiopathic P.A.T. with block, when it occurs in young people, is compatible with a long, healthy and active life. Freiermuth and Jick reported 40 episodes of paroxysmal atrial tachycardia with block.[9] In 15 of these instances the arrhythmia was not related to digitalis.

These authors observed that all instances in their series not associated with digitalis intoxication were associated with advanced degrees of organic heart disease. Other writers have likewise observed this arrhythmia with organic heart disease not being treated with digitalis. Thus those cases not related to digitalis appear to occur 1) in the absence of organic heart disease

and to have a significance somewhat similar to other types of ectopic supraventricular rhythm and 2) in patients with advanced heart disease. In the latter situation the arrhythmia takes on more grave implications.

Of the cases related to digitalis therapy, the occurrence of the rhythm disturbance, as will be discussed in a later section, was related to the state of potassium balance as well as to the quantity of digitalis present in the patient. In 1954, Lown and Levine[8] stated that in slightly over 80% of episodes digitalis was involved in the emergence of the arrhythmia. In 1958, Lown and Levine,[6] reporting 118 episodes, stated 83 (73%) were definitely related to digitalis, 12.5% were doubtfully so related and 14.5% were unrelated to digitalis. They also stated that from study of the electrocardiogram alone, differentiation between those related to digitalis and those not related was impossible.

Of those critically related to digitalis the following clinical classification was suggested: a) Those due to digitalis over dosage, b) those precipitated by mercurial diuresis, c) those with an augmented responsiveness to digitalis resulting in P.A.T. with block following small doses of digitalis prior to emergence of its therapeutic effect and finally d) a miscellaneous group. This group included cases induced by sensitivity to digitalis produced by measures other than diuresis. These included cases resulting from potassium deficit secondary to renal disease, following administration of cortisone and intravenous administration of calcium to a digitalized patient.

In summary, cases of paroxysmal atrial tachycardia with block may be grouped as outlined in Table I.

TABLE I

Classification

A. Paroxysmal atrial tachycardia with block unrelated to digitalis.
   1. In the absence of organic heart disease.
   2. Related to various etiological types of heart disease.

B. Paroxysmal atrial tachycardia with block related to digitalis therapy.
   1. Excessive digitalis dosage.
   2. Precipitated by diuresis.
   3. Resulting from an augmented responsiveness to digitalis (as in infarctions and active rheumatic fever)
   4. Increased sensitivity to digitalis secondary to factors other than diuresis.

C. Paroxysmal atrial tachycardia with block of questionable relationship to digitalis.

Clinical Features

At the outset it must be emphasized that bedside recognition of P.A.T. with block is rarely if ever possible with certainty. The most that one can hope to do is to be particularly aware of this possibility under circumstances conducive to its occurrence and to be suspicious of its presence with certain changes in the rhythm of the heart.

The setting for its occurrence as a toxic manifestation of digitalis is usually in a patient with advanced heart disease receiving, relatively speaking, an excessive dose of digitalis or being subjected to a situation which prompts a negative potassium balance. The relatively excessive dose of digitalis may occur during the process of digitalization or be the result of gradually increasing body level while on a maintenance dose. Factors conducive to a negative potassium balance include diuresis from any of the various diuretic drugs, cortisone and related hormones and glucose - insulin administration among others. Other symptoms of digitalis intoxication may or may not be present. This rhythm disturbance has been reported following myocardial infarction and rheumatic myocarditis in patients not necessarily receiving digitalis.

In spite of the name, it is well to remember that the ventricular rate, while frequently excessive, may be actually less than 100. The rhythm may be perfectly regular or it may be grossly irregular. Probably the most important bedside finding that should make one think of this disturbance is a sudden change in either rate or rhythm. In a patient with previously established atrial fibrillation, regularization and acceleration of the rate should arouse suspicion. Likewise, in a patient with a previously regular rhythm, the development of an irregular, more rapid ventricular rate should suggest P.A.T. with block. Since the degree of AV block decreases with exercise, the sudden doubling of the pulse rate after exercise with sudden halving of the rate after a few minutes rest suggests this

arrhythmia. Also, in patients with advanced heart disease, an unexplained increase in congestive failure may accompany the onset of P.A.T. with block.

With 1:1 AV conduction the patient may experience the usual symptoms associated with rapid ventricular rates from other causes, namely weakness, palpitation, drop in pressure, faintness and paleness. On the other hand, when the ventricular rate is not greatly in excess of normal, the patient may not be aware of the onset of a change in rhythm.

The definitive diagnosis of P.A.T. with block always depends upon the electrocardiogram but, as will be shown, occasionaly the routine tracing may fail to furnish necessary evidence for diagnosis. Under these circumstances one must be suspicious of this mechanism so that proper recording of the electrocardiogram will be done in order to demonstrate features necessary for diagnosis.

Electrocardiographic Characteristics

P.A.T. with block is an abnormal rhythm involving primarily the atrial mechanism but frequently resulting in a disturbed ventricular rhythm. Since the diagnosis of P.A.T. with block is dependent upon the EKG, it is obvious that certain criteria must be met. These are an atrial rate between 150 and 250, an iso-electric baseline between the P waves and the presence of spontaneous or induced atrio-ventricular heart block.[6] (Fig. 1)

This 35-year-old white female had hypertensive cardiovascular disease and was hospitalized with symptoms of severe congestive heart failure. Following digitalization and salt restriction her symptoms of heart failure subsided, but she died following a peripheral vascular embolus. Her electrocardiogram on entry showed sinus tachycardia. The above tracing, three days prior to death, revealed a classical P.A.T. with block and digitalis effect. The following characteristics are clearly shown: 1) Small sharp P waves, 2) an isoelectric baseline, 3) an auricular rate of 167, 4) a constant 2:1 atrio-ventricular block and 5) S-T depression secondary to digitalis effect.

Close study of the P waves is of some help. In the majority of cases the P wave is upright in one or more of the limb leads, most commonly lead II. Occasionally when P waves are not visible in the limb leads they can be found in lead V1 or V2, especially following carotid sinus pressure. Rarely they may not be visible in any of the routine leads and special atrial leads may be necessary for their demonstration. The contour of the P wave is usually different from that found during sinus rhythm.

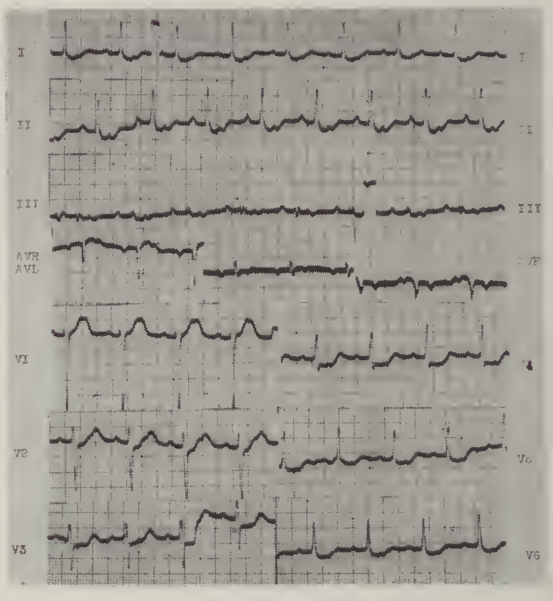


Figure 1

Classical P.A.T. with block and digitalis effect.

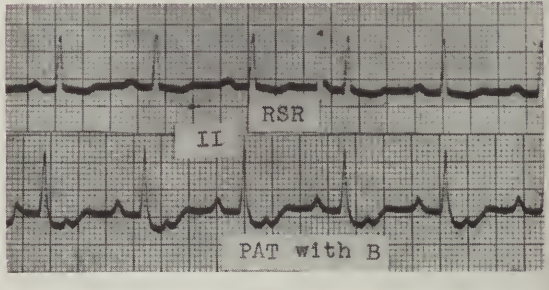


Figure 2

Change in configuration of P wave.

Figure 2 is lead II in the same patient as in Figure 1. The top strip shows regular sinus rhythm, and the lower P.A.T. with block.

This comparison demonstrates the change that may occur in the configuration of the P wave with change from regular sinus rhythm to P.A.T. with block.

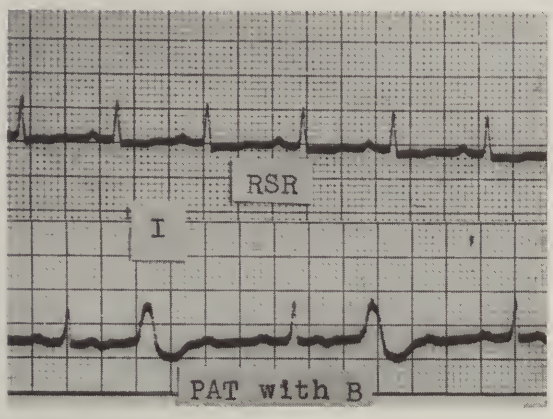


Figure 3

Strips of lead I showing regular sinus rhythm above, and P.A.T. with block below.

This 70-year-old white male was admitted with signs and symptoms of chronic congestive heart failure and digitalis intoxication. He had been receiving both digitalis and repeated doses of mercurials. An elecrocardiogram on 6-27-57 revealed P.A.T. with a variable degree of atrio-ventricular block and multiple premature ventricular contractions. Digitalis was withheld and 40 mEq. of potassium chloride in 500 cc of 5% glucose in water was given intravenously. The following day his rhythm was regular and on 6-28-57 an electrocardiogram showed regular sinus rhythm. These strips of lead I show regular sinus rhythm above and P.A.T. with block below. Note in this example that the P waves in P.A.T. with block become smaller and more nearly flat rather than sharper as is illustrated in Figure 2.

Most often in P.A.T. with block the P waves are smaller and narrower than the normal P waves. It should be noted that the individual leads containing the most prominent P waves vary from case to case.

One differentiating characteristic of P.A.T. with block is its variable atrial rate. The P-P cycle variation may be from 0.0 to 0.12 seconds and in most cases is detectable only with careful measurements. This variation in the P-P interval is important in differentiating a conventional paroxysmal atrial tachycardia from a P.A.T. with 1:1 conduction.

The presence of an isoelectric baseline between the P waves is essential for the diagnosis of P.A.T. with block. This is especially useful in differentiating atrial flutter from a rapid P.A.T. with block.

The presence of atrio-ventricular block in some form is essential for the diagnosis of P.A.T. with block. This may vary from first degree block to complete atrio-ventricular block. At times P.A.T. with block may not exhibit defective AV conduction, there being a 1:1 atrio-ventricular mechanism. In this situation the latent atrio-ventricular block may frequently be demonstrated by carotid sinus pressure, thus serving to differentiate this mechanism from classical paroxysmal atrial tachycardia. This vagal stimulation results in a change in atrio-ventricular conduction without a change in the atrial rate. If atrio-ventricular block already exists, carotid sinus pressure usually results in the development of a higher grade block. This fact alone serves to suggest P.A.T. with block as well as to suppress the ventricular activity, thus allowing the atrial waves to be more carefully studied.

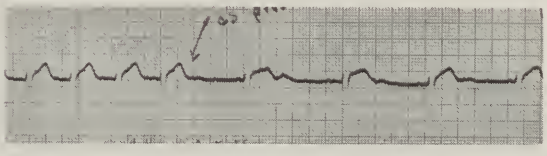


Figure 4

The production of increased A-V block by carotid sinus stimulation.

This 69-year-old man had arteriosclerotic heart disease with chronic congestive failure. He developed P.A.T. with block, but omission of digitalis and the administration of potassium chloride did not result in correction of this rhythm disturbance. Quinidine and Pronestyl were also ineffective. The ventricular rate was controlled for two years whereupon there was spontaneous conversion to regular sinus rhythm. The above strip of lead V-1 illustrates the production of increased A-V block by carotid sinus stimulation with better demonstration of atrial activity.

The degree of A-V block may be constant resulting in a regular ventricular rate. (Figure 1). In some cases however, there is a constantly changing degree of A-V block resulting in an irregular ventricular rhythm.

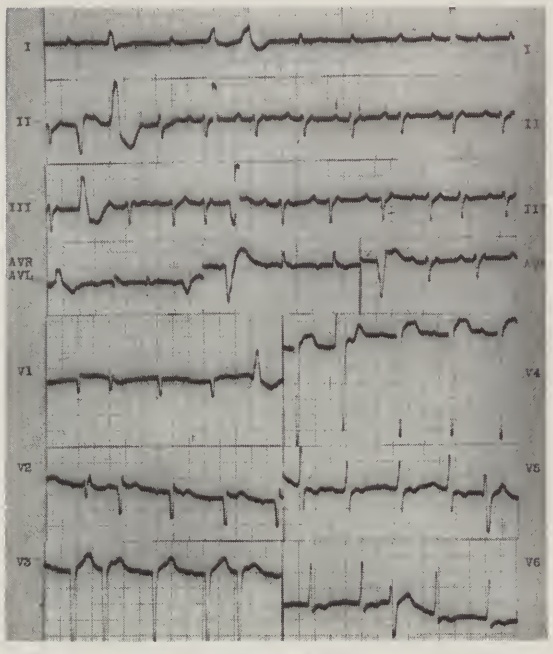


Figure 5

Variable atrio-ventricular conduction.

This 67-year-old white male was admitted in congestive heart failure, having omitted his digitalis five weeks prior to hospitalization. He developed a hemiplegia and expired four hours after admission. The above electrocardiogram reveals P.A.T. with variable atrio-ventricular conduction and ectopic ventricular contractions. This is an example of P.A.T. with block not resulting from digitalis.

In most of the reported cases the onset and end of this arrhythmia was thought to be abrupt. However, Lown and Levine[8] reported 28 episodes in which the termination of the arrhythmia was carefully studied during the administration of potassium. They noted two distinct phases. First a gradual slowing of the atrial rate with a decrease in atrio-ventricular block and, secondly, a change in the ectopic pacemaker. In nine of their patients the onset was also studied and in the majority of these the onset was similar to the end; however, two of these nine showed an abrupt onset and end. The qualitative change in the contour of the P wave noted above was further verified by the occurrence of atrial premature beats either before or after the episode of tachycardia and these premature atrial beats revealed P waves very similar to those seen during the episode of P.A.T. with block. In some of those episodes related to digitalis toxicity there were associated EKG changes of digitalis effect. (Figure 5)

Electrocardiographic Differential Diagnosis

Lown and Levine aptly referred to P.A.T. with block as a "hybrid arrhythmia" since it resembled in some ways both atrial flutter and conventional atrial tachycardia.[8] This similarity goes even farther in that this rhythm disturbance may closely resemble nearly every atrial mechanism. Careful study of the electrocardiogram with this rhythm disturbance constantly in mind is essential if this atrial mechanism is to be recognized. It was evident in a rather large series that most cases of paroxysmal atrial tachycardia with block are clear-cut electrocardiographic entities and present no great difficulty in diagnosis.[6]

There are, however, some examples of this arrhythmia that tax the electrocardiographer to the utmost. In these cases, knowledge of the clinical situation is of great help in recognition. Since the majority of cases of P.A.T. with block occur as a complication of digitalis therapy, knowledge of the state of digitalization, recent change in digitalis dosage or the presence of factors influencing potassium balance lowers or heightens one's suspicion that a given rhythm disturbance may be this mechanism.

Even though other evidence of digitalis effect in the electrocardiogram may speak in favor of this abnormality, it is wise to remember that digitalis intoxication may exist even when the S-T-T complex reveals no evidence of digitalis effect.[6] In evaluating digitalis overdosage, Kay stated[10] "the fallacies of clinical judgment and of the patient's memory are better avoided by means of a telephone than electrocardiograph." It is thus apparent that the state of digitalization cannot be accurately determined from study of the electrocardiogram.

Clear-cut atrial deflections may not occur in the standard extremity leads and occasionally may even be absent in the precordial leads. It may be necessary to record leads from the high right or left parasternal areas coupled through the CR or CF switch of the electrocardiograph to demonstrate the atrial mechanism.

Some confusion may arise in differentiating P.A.T. with block from the various sinus

mechanisms. It is not unusual to see a regular ventricular rate less than 100 in the presence of P.A.T. with block. In this situation AV block is always present. The blocked P wave may be superimposed upon the preceding ventricular complex and thus not readily recognized. The presence of such a situation may be suspected from an apparent deformity within the ventricular complex. Better demonstration of these blocked and hidden P waves may be obtained by recording any lead of the electrocardiogram that contains well defined P waves during carotid sinus pressure. (Figure 4). The increased AV block that usually results in this disorder allows ready recognition of the rhythm disturbance. Needless to say, one must be suspicious of an abnormal mechanism before this procedure is thought of.

Variation

Frequent premature atrial contractions, particularly if some are blocked, may superficially resemble P.A.T. with block. As previously pointed out[6] there may be some irregularity of the P-P interval in P.A.T. with block. This is very minimal, usually varying from 0.02 seconds to 0.12 seconds. In most cases, however, this variation in atrial rate is not grossly apparent and careful measurement with calipers is necessary for recognition. On the other hand, the variation in atrial rate and regularity is grossly apparent in electrocardiograms demonstrating frequent atrial premature contractions.

In the absence of AV block when the atrial rate is relatively slow, and particularly if one is not aware of the appearance of the electrocardiogram before the onset of arrhythmia, P.A.T. with block may closely resemble sinus tachycardia. This difficulty may be further increased in trying to compare the P waves before and after the onset of tachycardia if one remembers that with the occurrence of sinus tachycardia the P wave may normally become smaller.[6] Thus somewhat apparent changes in the P wave with the onset of sinus tachycardia may not actually indicate a change in the basic atrial mechanism, and even with the previous tracing for comparison care must be exercised. Here again, carotid sinus pressure with the production of transient AV block is diagnostic.

In patients with a rapid atrial rate of sinus origin having an accompanying high-grade AV block, differentiation from P.A.T. with block may be difficult. This problem becomes more apparent when it is remembered that cases of P.A.T. with block have been described in which in all respects the background and EKG pattern were characteristic, however, reversion to sinus rhythm was not associated with a change in the contour or the size of the P waves.[6] An electrocardiogram with these features may represent sinus tachycardia with an associated but independently determined AV block or P.A.T. with block. Lown and Levine[6] point out that proper evaluation of the electrocardiogram is impossible without knowledge of the clinical picture. In those cases exhibiting unaltered P waves with the onset of P.A.T. with block, the atrial rate above that is usually seen in sinus tachycardia and the presence of varying AV block is helpful in differentiation.

In the unusual case of P.A.T. with block in which P waves cannot be easily identified the rhythm may appear to be nodal. Even when no P waves can be seen in the limb leads, careful inspection of V1 or V2 usually reveals atrial activity. Rarely, however, even in these leads no atrial waves are visible. In this situation the special atrial leads coupled through the CR or CF terminal may clarify the diagnosis.

Conduction

As pointed out in a previous section, the AV block may be only potential, there being a 1:1 atrio-ventricular conduction. During the evolution of P.A.T. with block, 1:1 conduction is not at all unusual. Under these circumstances the rhythm disturbance may resemble conventional paroxysmal atrial tachycardia. Such a 1:1 conduction may continue for hours or days and the only method to differentiate with certainty between these two is either to observe spontaneously occurring AV block or the production of AV block with carotid sinus pressure. Conventional paroxysmal atrial tachycardia in response to carotid sinus stimulation either suddenly is converted to sinus mechanism or no effect at all occurs. It never reponds with increased AV block as is characteristic of P.A.T. with block. Field, Barker and Alexander reported a patient with pre-existing atrial tachycardia whose AV

conduction was depressed by digitalis, resulting in AV block,[11] but this apparently is very unusual.

Very small P waves, variable ventricular rate and variation in atrial rate may result in P.A.T. with block resembling atrial fibrillation.

Figure 6 illustrates that P.A.T. with block may superficially resemble atrial fibrillation. Careful observation is necessary to avoid error in electrocardiographic interpretation.

In the right precordial leads in some cases of atrial fibrillation one may see rapid fairly regular waves of atrial origin. They occur more rapidly than 250 per minute and should not be confused with P.A.T. with block. (Figure 7)

Figure 7 is lead V1 in a patient with atrial fibrillation. It illustrates the possibility of confusing these waves of atrial activity with the P waves seen in P.A.T. with block. Note they are more rapid than P waves in P.A.T. with block.

Many years of atrial fibrillation do not preclude the development of P.A.T. with block.[8] Again, the nature of the mechanism can be identified by careful search for P waves especially in the right precordial or special atrial leads with carotid sinus stimulation. Acceleration and regularization of the rate in atrial fibrillation, either after increased digitalis dosage or sustained potassium deficits, should raise the suspicion of P.A.T. with block. The development of a grossly irregular rhythm in a patient receiving digitalis should suggest P.A.T. with block.

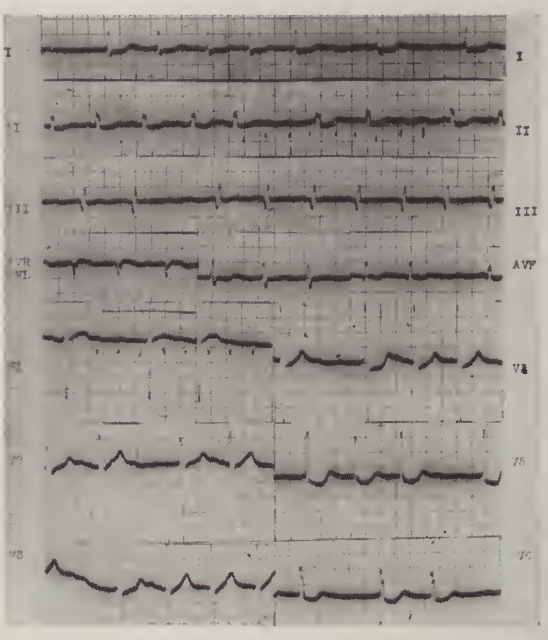


Figure 6

P.A.T. with block resembling atrial fibrillation.

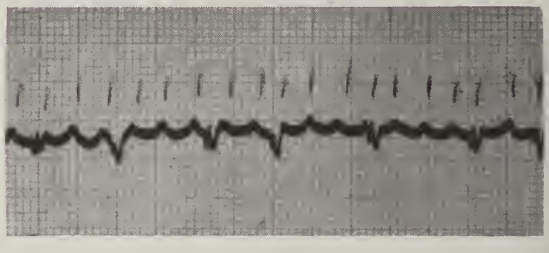


Figure 7

Atrial fibrillation which might be confused with P.A.T. with block.

Of all the atrial mechanisms that must be differentiated from P.A.T. with block, atrial flutter presents the greatest difficulty. The close similarity in some cases may make differentiation impossible. Prinzmetal, et. al., proponents of the unitarian theory of atrial arrhythmias, regard P.A.T. with block as a flutter variant and feel that P.A.T. with block and flutter are not distinct electrocardiographic mechanisms.[12,13] They feel the ectopic focus rate determines largely the type of rhythm disorder. The undulant base line in flutter is thought to result from the emergence of larger and larger atrial T waves with increase in the atrial rate. The succession of P waves followed by oppositely directed atrial T waves in sequence results in the absence of an isoelectric interval and the characteristic flutter undulations. As the atrial rate decreases, the atrial T wave decreases in size and eventually disappears at rates below 250.

Lown and Levine, on the contrary, feel that variations in the rate of discharge of the ectopic atrial focus do not fully account for the genesis of the electrocardiographic features of flutter. They point out that atrial flutter may retain the undulant baseline when the atrial rate is slowed below 250. They also pointed out the maintenance of the basic flutter features in a case with spontaneous variation in the flutter rate from 330 to 156 while being maintained on digitalis alone.[6]

Since the therapy of P.A.T. with block and flutter differ greatly, differentiation between these arrhythmias is important. In untreated flutter the atrial rate is usually above 250. With

few exceptions, mechanisms having an atrial rate above 250 should be classified as flutter, irrespective of whether the baseline is isoelectric. If only one lead reveals continuous undulations of the baseline the most likely diagnosis is atrial flutter if undulations occur regularly. Lown and Levine[6] after study of 40 patients with classical flutter pointed out that in untreated flutter, AV block is usually 2:1 (63%) whereas in P.A.T. with block only 1/3 revealed predominant 2:1 AV block.

A constant cycle length (varying less than 0.01 seconds) occurred in all cases of flutter but in only half the patients with P.A.T. with block. Only 3 of 40 patients with flutter had atrial rates less than 250, the mean atrial rate being 310. The mean atrial rate in P.A.T. with block was 181. Trial with potassium may serve as an important therapeutic test.

Atrial rates in the range usually seen in P.A.T. with block may occur during the treatment of atrial fibrillation or atrial flutter with quinidine. Due to slowing of intra-atrial conduction, prominent, broad biphasic P waves may appear in V1. Such P waves, however, do not occur in P.A.T. with block and furthermore the circumstances under which they occur aid in the differential. In some cases receiving quinidine, the P wave may be indistinguishable from those seen in P.A.T. with block and here only knowledge of the clinical picture serves to identify the mechanism.

Potassium and Digitalis Interrelationship

The variable tolerance of the myocardium to digitalis has been known for a number of years. There are many factors, some known and some unknown, which modify greatly this sensitivity to digitalis. Fatal results have followed the intravenous injection of calcium in digitalized patients.[14] A number of reports have dealt with the abolition of rhythm disturbances due to digitalis with intravenous magnesium.[15,16,17]

For many years physiologists have recognized the importance of potassium ions for normal myocardial function. Profound effects upon the heart may result from alteration of the body potassium. Changes in extracellular potassium accompanying changes in body potassium content may result in alterations in the electrocardiogram. The changes resulting from both hyperkalemia and hypokalemia are well known.

Toxic doses of digitalis result in liberation of potassium from the myocardium.[18] The action of digitalis is profoundly influenced by changes in potassium. Various reports agree that potassium is effective against many digitalis induced rhythm disturbances. Buff reported that potassium salts also eliminate the symptoms of overdosage and rapidly promote a sense of well-being in the patients with digitalis poisoning.[19] Pick suggests that potassium may counteract not only digitalis toxicity but also the therapeutic effects of the drug.[20] Patients with advanced congestive failure under treatment with digitalis may experience symptoms of digitalis intoxication twenty-four to forty-eight hours after diuresis.

This sequence of events is known to occur only when significant losses of potassium occur. There is good evidence that a negative potassium balance precipitated by diuretic therapy results in increased myocardial sensitivity to the toxic properties of digitalis. It is further known that losses of potassium potentiate the toxic action of digitalis irrespective of cause. The sensitivity of the heart to digitalis is more dependent upon the body potassium balance than upon serum level. As a rule the post-diuretic increased myocardial sensitivity to digitalis is not reflected by the serum potassium level.

There is much evidence that the potassium concentration in the body is a key factor which determines the reactivity of the heart to digitalis. The various measures in current use for producing a negative sodium balance also predispose to depletion of body potassium. Mercurial diuretics are a major cause of potassium depletion. This tendency toward a negative potassium balance after mercurial diuretics is accentuated by prolonged and rigid salt restriction.[21] The more advanced the congestive failure the greater the tendency to lose significant quantities of potassium after mercurials. Potassium losses are further increased by the administration of ammonium chloride prior to the mercurial. Other commonly used drugs as Diamox, cationic exchange resins and chlorothiazide may also cause serious potassium deficits.

Lown and Levine[6] have conclusively shown in both experimental animals and in patients

that P.A.T. with block may be induced by digitalis. These experiments were conducted using acetyl strophonthidin, an ultra quick acting synthetic ester of strophanthidin. They demonstrated the precipitation of this rhythm disturbance in the presence of subtoxic doses of digitalis by promoting potassium loss in patients under treatment with the artificial kidney. A positive potassium balance was shown to protect patients from the toxic effects of a previously determined toxic dose of digitalis.

It is apparent that the occurrence of P.A.T. with block following digitalis is determined not only by the actual quantity of digitalis in the body but also by the state of potassium balance existing at that particular time. Other factors are without doubt involved as well. Knowledge of these facts serves to guide the clinician when faced with the problem of this and other rhythm disturbances present or impending during the course of digitalis therapy.

Treatment

The first therapeutic step in digitalis induced P.A.T. with block is obviously to discontinue the digitalis. Furthermore, the avoidance of further potassium depletion by the omission of diuretic agents is important. Otherwise, the arrhythmia may continue. This applies to other drugs such as cortisone, insulin and glucose, as well as the usual diuretic agents.

Potassium is effective in combating the toxic effect of digitalis and controlling the arrhythmia. It is given as potassium chloride in a dosage varying from 20 - 120 mEq. (1.5 to 9.0 grams). The average dose necessary to abolish the arrhythmia was found by Lown and Levine[6] to be 58 mEq. Potassium chloride may be given orally (5.0 grams) and will usually be effective in several hours. If this amount is ineffective, an additional 2.5 grams may be given every four hours for two or three doses. If the rhythm has not converted after 100 mEq., other measures should be tried. It is of interest that potassium may be effective not only in controlling the arrhythmia but also in ameliorating the signs of congestive heart failure when these are secondary to digitalis intoxication.

In those patients who are vomiting or who are in advanced cardiac failure and cannot tolerate a prolonged 1:1 response with its associated rapid ventricular rate, intravenous potassium is indicated. This results in prompt action and one which can be stopped when the desired effect is reached, provided continuous EKG control is available. The usual infusion consists of 3.0 grams (40 mEq) of potassium chloride in 500 cc of 5% glucose in water over a 1 - 3 hours period. If slowing of the atrial rate is not apparent with this dosage, further potassium is likely to be ineffective[6] and possibly dangerous.

Caution should be exercised in the use of potassium, since both elderly patients and those with heart failure are more susceptible to potassium intoxication than a normal individual. In general, the more severe the failure, the smaller the initial dose of potassium and the longer the interval between doses.

Procaine amide is also effective in P.A.T. with block and it may be given orally 1.0 gm. initially followed by 0.5 gm. every 3 - 6 hours. Again it must be used with caution in advanced heart failure or in patients with renal impairment since approximately 60% of it is excreted by the kidneys. If given intravenously, the dose is 50 mg. every two hours with blood pressure checks prior to injection; however, hypotension is so frequent with intravenous use that the intramuscular route seems safer and the effect almost as rapid. In those patients with any degree of shock, the use of intramuscular procaine amide may result in procaine amide intoxication following emergence from shock because of sudden rapid absorption from the intramuscular sites.

Procaine amide in conjunction with potassium is especially important in patients with severe congestive failure with rapid atrial rate. The use of these two drugs together tends to complement each other and make a smaller dosage of each necessary and, furthermore, shortens the time necessary for conversion to sinus rhythm.

There is no uniformly effective treatment of the non-digitalis induced P.A.T. with block.

There is no relationship to potassium in this type and thus potassium is ineffective. It has been shown that digitalis may be of value in controlling the ventricular rate in this type of P.A.T. with block.[8]

Summary

The clinical features, electrocardiographic characteristics, treatment and, in particular, the differential diagnosis of paroxysmal atrial tachycardia with block have been presented. We have emphasized the not unusual occurrence of this rhythm disturbance, the circumstances under which it is likely to occur and the necessity of being ever aware of this possibility if the correct diagnosis is to be made.

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Robert S. Garber, M.D., F.A.P.A.**

Belle Mead, N. J.

The psychiatrist can best be of help to the generalist in retaining his role as a physician and in communicating with his colleagues in simple, clear language about their own patients

Historical

PROBABLY the first planning for a program of Psychiatry for the Generalist was done at a meeting of military psychiatrists from World War II. The ideas developed were published in a volume titled "Teaching Psychotherapeutic Medicine." These meetings occurred on the campus of the University of Minnesota in the spring of 1948, under the sponsorship of the Commonwealth Fund.

The next most noteworthy example occurred at the North Shore Hospital[1] in Illinois which for the past eight years has presented programs designed for this purpose. The American Psychiatric Association established a Liaison Committee to work with the American Academy of General Practice and also appointed a full-time psychiatrist[2] in the furtherance of such programs. About the same time (November, 1956), the Annual Conference of Mental Health Chairmen, sponsored by the American Medical Association,[3] suggested the time had come to start such programs.

It was with this firm foundation in mind that the staff of the Carrier Clinic decided to embark upon such a venture for the benefit of the New Jersey Chapter, A.A.G.P. In the fall of 1956, a questionnaire was circulated among the several hundred members to determine their need and their willingness to participate, and soliciting suggestions for the topics desired. In the spring of 1957, on the campus of Princeton University, 18 lectures, spread over six consecutive Wednesday afternoons, were offered as a direct result of this poll to a group which eventually made such a demand for the abstracts that the Smith, Kline and French Mental Health Foundation was called upon to supply the 26,000 copies requested.

This program was followed by a critique inviting the participants to criticize the offering and to suggest further advice. As a result of the information obtained, our second series was held in the fall of 1958. The registration was double the original number of participants. Requests for the abstracts of these papers continue to be filled at this time.

Source

There are five sources for the information contained herein:

1. From the reactions of the New Jersey and Pennsylvania practitioners participating in the first and second seminar series given at the Carrier Clinic.[4, 5]

2. Information gleaned from approximately 11,000 general practitioners who are regularly receiving a quarterly publication titled "Abstracts of Psychiatry for the General Practitioner."[6]

3. From "Psychiatric Problems and Prefer-

**Delivered at the Annual Meeting of the Kentucky State Medical Association, before the section meeting of the Kentucky Psychiatric Association, September 23, 1959.*

***Medical Director, The Carrier Clinic, Belle Mead, New Jersey.*

ences for Instruction"[7] wherein it was reported "Interests of non-psychiatrist physicians in various aspects of Psychiatry and their attitudes towards Psychiatry were studied by a questionnaire method with responses from 338 non-psychiatrists."

4. From a paper titled "The General Practitioner and the Psychiatrist"[8] concerning a questionnaire sent to 600 members of the Washington State Academy of General Practice. The comments contained were the results of 416 questionnaires completed and returned.

5. Personal and telephone interviews of 30 outstanding New Jersey practitioners this past month as to what they thought were the pertinent issues on which psychiatrists needed to be briefed.[9] Interestingly, although these sources emanated from various areas of the country, there is a remarkable similarity of the results and a considerable consistency of the ideas as to what should be offered.

In the hope of avoiding repetition and for the sake of expediency, the responses will not be differentiated as to their sources since these replies denote the consistent thinking of generalists in several sections of our country.

Psychiatric Education

A. The G.P.'s professed concern of his lack of knowledge of the subtleties of office interviews and treatment techniques is a consistent reflection on his undergraduate education and can perhaps be best illustrated by the following quotations:

1. "Too many cases were shown of psychoses which we refer anyway and not enough attention was given to the borderline office cases; such as anxiety tension states."[8]

2. "Our medical school course was impractical, with too much theory and almost no demonstration of ordinary counselling techniques such as I have to use every day in my practice. To make up for this, psychiatrists should keep on teaching us at our county medical society or hospital staff meetings but mostly with their own patients that we refer to them."[8]

3. "I feel a little inadequate in office interviews where my stethoscope, thermometer, and examining table are removed, also in treatment where my hypo needle, prescription pad, etc., are taken away. What can you do to help me with these unfortunate people?"[6]

B. Another problem which seems to arouse much anxiety in the general practitioner is that of the patient's anxiety—how to avoid its arousal and how to cope with the situation when it occurs; similarly and quite closely related is how to avoid manipulation by certain patients.

C. The generalist needs to understand the problems of countertransference and the gradual realization of the part it plays in the treatment of a particular patient even though the ailment may be primarily a physical one. This was brought home to one generalist during a period when he did not feel well himself and was consequently inclined to be terse and irritable in his dealings with patients. Gradually he awakened to the fact that his patients were getting very little out of their visits to him on these occasions and that they weren't even responding to simple suggestions relative to the method of taking their medication. This physician went on to report how meaningful it was to begin to understand his own emotional attitude toward his patients.

Another physician commented that he was now able to recognize that he became persistently annoyed with a particular patient whom he had hated for many years. As a result of the literature we had provided and the seminars he had attended, he is now able to realize how much more clearly what had been happening between himself and the patient he had despised so much. This physician further reported that with his change of attitude he was able to sense a positive response on the patient's part.

A number of general practitioners reported that they felt terribly guilty about seeing patients with psychiatric problems or confirmed neuroses. They recognized that actually they did not want to see them and that they felt uncomfortable about carrying patients for a prolonged period of time and giving them nothing more material than "talk" to help them with their illnesses. Each of these general practitioners related that he is much more aware of his necessary role in the patient's treatment and since he has attained this awareness he has been able to change his own attitude towards

his patients. The first practical step taken by a number of them developing this insight was a rescheduling of office visits to allow more time for discussion of the many emotional factors involved.

D. The generalists repeatedly inquired into the method by which danger signals may be recognized in time in order to make appropriate referrals. They constantly lament about the psychiatric jargon, especially terms of a psychoanalytic nature. They repeatedly appeal for information that is strongly utilitarian and of immediate aid; that is, they are not generally interested in keeping ahead of current research developments or new theories, but prefer practical material.

Patients the Generalist Encounters

Not well recognized as a need by the general practitioner is the necessity to develop partial insight into personal reactions and into doctor-patient inter-reactions regardless of the nature of the presenting complaints. This can perhaps best be illustrated by the following:

"After attending both of your series of lectures I have now come to the realization that I have been doing many of these things in my relationship with my patients all my life and never gave myself any credit for it, but now that I have some understanding in the mechanisms involved I am certainly going to give myself appropriate credit, so that as a result I will learn to like myself better."[6]

The main complaint about psychiatric patients in general practice was that they take too much time, as illustrated by the following:

"These patients take a lot more time and are less remunerative than other patients."

The complaint that these patients are difficult ones to help as envisioned by the following:

"My results with these patients are hampered by the fact that often there is not much to work with or the environmental pressures are so overwhelming and there is not much I can do to correct them."[8]

Psychiatric Referrals

The bulk of respondents throughout the nation from the group studied replied that they would like to refer more of their patients to the psychiatrists. However, it was generally found they hesitate to do so because of:

1. The expense to patients.
2. The lack of available psychiatrists in their areas.
3. The failure of psychiatrists to have been of much help to them in the past.
4. The difficulties encountered in referring a patient to a psychiatrist.

Some typical comments are as follows:

"The patients who need psychiatric care the most often resist such a suggestion. It is often hard for me to get a patient to accept an emotional cause for his illness and I have to approach the problem obliquely or lose the patient."[8]

"I would like to refer more patients but only the well-to-do can afford psychiatric care and few of my patients fall into this class, especially when the results are often uncertain."[8]

A contrary thought is voiced in:

"The general practitioner must be willing to take the time to screen those who need only to ventilate on an interested ear. Then the psychiatrist would not be overwhelmed with junk which causes his appointments to be filled for many weeks in advance and thus he could become a truly helpful consultant for emergency problems."[9]

Criticisms of Psychiatrists

A very large percentage of the groups tested were exceedingly more critical of psychiatrists than any other specialists for the following reasons:

1. Psychiatrists are unrealistic in their problem solving.
2. They are too unstable themselves.
3. They seldom help their patients.

Rather typical comments are as follows:

"Psychiatrists are involved in an intangible science with dubious results after prolonged consultations and particularly since they are 'costly fellows' the majority of patients can't afford them."[9]

"Only too often my patients tell me that the first discussion with a psychiatrist is a discussion of the fees to be paid. I do not practice this way nor do any of the other doctors I know."[8]

"Psychiatrists should be doctors first and

psychiatrists second. We never see them at staff or medical meetings."[8]

"I get up at 3.00 A.M. to see patients, yet when I have an emergency psychiatric case the psychiatrist's secretary won't let me talk to him and when he eventually does call back he can't see my emergency patient for at least three weeks."[8]

Contrary to the usual feeling that the general practitioner is content to have the psychiatrist treat the patient with psychopharmacology or electric shock, there is a substantially large number of men who are in disagreement with this method of approach, as illustrated by the following:

"It is hard to find a good psychiatrist, some of them want to give most of the patients I refer a classical psychoanalysis, others rush them into shock treatments and tranquilizers when all that I had in mind was some experienced counselling for the patient."[8]

A vast number envision the psychiatrist as considering all illnesses as due to the psyche and very few to the soma.

Physician's Areas of Interest

Although the following table was extracted from a Nebraska Psychiatric Institute paper, it conforms consistently with the conclusions drawn from other areas. The most popular subjects requested for instruction in psychiatry by general practitioners according to the per cents of interests were listed as follows:[7]

1. Physical and drug therapy.
2. Diagnoses.
3. Psychiatric aspects of family counselling.
4. Causes.
5. Psychotherapy.
6. Neuropsychiatric outpatients.
7. Community mental health programs.
8. Legal problems in psychiatry.
9. Commitment procedures.
10. Hospitalized neuropsychiatric patients.
11. Referral problems.

Interest In Postgraduate Courses

From the Nebraska Psychiatric Institute only a small percentage of the respondents were interested in courses in Psychiatry. Roughly, one-third were interested in Neurology, whereas the bulk of the group, approximately 60%, were looking for a combined course in Neurology and Psychiatry.[7] This is probably the only occasion where this is a marked discrepancy according to the area polled; for those in the eastern area, the Carrier Clinic poll revealed a predominant majority who favored topics solely of a psychiatric nature.

Problems of Communication

The problem of communication between psychiatrists and non-psychiatrists appears to be in dire need of solution. Although descriptive psychiatry has not been fashionable for some time, a clarification of the signs and symptoms by which those who are emotionally ill may be recognized, as well as the dynamics of a particular case, might make communication less a problem.

A goodly percentage of the generalists in various groups polled complained of the lack of or the inadequate nature of psychiatric reports to them; for example:

"Psychiatrists should keep the family doctors informed of the patient's progress. Too often we never hear from the psychiatrist at all or few of them ever tell me what is really wrong with the patient or how I should proceed with treatment."[8]

"Many times when the family comes in to discuss the case I should be able to help, but the psychiatrist has remained incommunicado. Our is a difficult position, a difficult one as the uninformed middleman."[8]

"The psychiatrist often fails to check with me regarding the environment and goes on just what the patient tells him. I am familiar with the whole picture and background of the case."[8]

Basic Requests

Basically, the general practitioner asks for the following:[9]

1. A method of simple, early recognition of potentially serious mental illness presented in such a fashion as to eliminate statistics and deal primarily with diagnosis and treatment.
2. Clarification as to what medications or early treatments can be safely prescribed for a patient prior to seeing a psychiatrist.
3. More pertinent information as to the time element; namely, danger signals in regard to referring a patient to a psychiatrist.

4. Greater assistance as to how they can encourage their patients to accept psychiatric treatment with the least amount of trauma; advice as to necessary procedures to be taken in getting patients into mental hospitals, particularly assistance in regard to legal aspects, methods of transmission—that is, under physical or chemical restraint, duress, or force by police officers.
5. More specific information as to what the psychiatrist desires from a general practitioner in the way of a detailed family or personal history or other pertinent facts in relation to the referral.
6. Further edification to alert them regarding organic diseases that may contribute to abnormal mental reactions frequently mistaken for psychotic states.

Advice for the Psychiatrists

1. We should take a renewed and strenuous interest in the offering of undergraduate and postgraduate courses to all interested non-psychiatrists. We should develop greater participation in medical school curricula, in county medical society meetings, in Chapters of A.A.G.P., and particularly in participation in general hospital staff meetings.
2. All such educational efforts should follow the generally found areas of interest; namely, physical and drug therapy, diagnoses, psychiatric aspects, family counselling, etiology, psychotherapy bearing in mind that intensive psychoanalytic procedures are usually questioned by most generalists.
3. We should make efforts to explain some of the unusual practices that are perplexing to our non-psychiatric confreres, such as:
   (a) The failure to answer other doctor's calls during a therapeutic session.
   (b) Giving preference to patients with a better prognosis rather than those with a poorer prognosis, requiring lengthy treatment.
   (c) The necessity of establishing a fee schedule before prolonged treatment is undertaken.
   (d) The need for charging other doctors and members of their families under therapy.
4. We must become aware of the absolute necessity of increasing methods of communication so that the referring physician has some knowledge as to the treatment program undertaken and what help he can give to members of the family in sustaining a stable family constellation.
5. We need to become more commonly known as members of a general hospital staff; that is, there is a need for increased participation in staff meetings, allotment of time for in-patient and out-patient consultations, opportunities to be seen and observed in hospital corridors so as to promote a better flow of communication with our non-psychiatric colleagues.
6. We must step down from our pedestals to become more human and understandable to our confreres, as illustrated by the following:

"Psychiatrists should be more human and a friend to the patients instead of acting afraid that the patients will seduce them. They should stop acting aloof, allow themselves to be seen, and help us all get acquainted with them."

Summary

1. We are in need of more literature to be offered in medical journals, particularly for the general practitioners consumption. These articles should contain practical "know-how" or a sort of "do-it-yourself manual" for the family physician who has to cope with a wide variety of direct and reactive neurotic conditions in his practice. In addition, we need articles which advise the physician when to consider seeking more specialized consultative help.
2. In the matter of postgraduate education, general practitioners prefer clinical presentations, local speakers, a presentation of patients from the institutions where the courses are given, brief presentations of cases illustrating physical and drug therapy, and more informal discussions of the borderline or office type cases.

3. The main complaint about psychiatric patients is that they take too much time, and are often difficult to help.
4. The generalist's chief objections to referring patients to psychiatrists were:
   a. Expense to patient.
   b. Resistance on the part of the patient.
   c. The lack of available psychiatrists.
   d. Only a remote response to the therapy offered.
5. Consistently, the general practitioner complains about the psychiatrists regarding
   a. Their lack of availability.
   b. The inadequate nature of psychiatric reports coming back to them as referring physicians.
   c. Failure to bring themselves down to a level with their fellow-professionals.
   d. Too unrealistic in their problem solving.

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6. A paper delivered at the 115th Annual Meeting of the American Psychiatric Association in Philadelphia on April 29, 1959, titled "Reactions of the General Practitioner to a Psychiatric Abstract Service." Published in the Journal of the American Psychiatric Association, October, 1959.
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8. By Lamere and Kraabel from the Department of Psychiatry, University of Washington in Seattle and read at the 115th Annual Meeting, APA, in April of 1959, and published in the Journal of APA in December, 1959.
9. Personal Interviews conducted by the author.

Suggested Reading

1. Panel Discussion on Psychiatric Emergencies in General Practice—Auerback, et al. Journal of the American Medical Association, June 27, 1959.
2. Practical Steps for the Family Physician in the Prevention of Emotional Disorders—Gerald Caplan, M.D. Journal of the American Medical Association, July 25, 1959.
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Ocular Manifestations of the Chronic Renal Tubular Insufficiency Syndromes

It is now possible to explain the association of certain conspicuous types of ocular disorder with insufficient renal tubular reabsorption. Three such disorders are Lowe's cerebro-ocular syndrome (congenital or early infantile cataract with hydrophthalmos), pseudohypoparathyroidism, and Fanconi's syndrome (vitamin D-refractory rickets with other extensive metabolic disturbances). A case of Lowe's syndrome in a boy-baby 3 months old is described with emphasis on the ocular and urinary findings. Pseudohypoparathyroidism was observed in a man aged 39 who had always been confined either to his home or to an institution because of profound mental and physical deficiencies including progressive impairment of vision. In Fanconi's syndrome (not illustrated) cysteine crystals appear in the conjunctiva and cornea. These disorders are readily understood when it is considered that renal tubular reabsorption concerns the phosphates, amino acids, and basic elements. They are important to the ophthalmologist because the characteristic findings enable him to contribute valuable diagnostic information to the internist and others concerned in the treatment of these severe derangements of metabolism. Exact diagnosis is essential not only for effective treatment but also for counselling families in which these derangements occur.

Harold F. Falls, M.D., AMA Arch. Ophth., August 1959

Louisville General Hospital

Pulmonary Tuberculosis With Pleural Effusion

(Report of a Case Treated with Steroids)*

E. C., an 11-year-old colored male, was admitted to the Pediatric Service of the Louisville General Hospital on September 29, 1959, with the chief complaints of cough and left chest pain.

Four days prior to admission the patient became lethargic, anoretic, and developed pain in his left hemithorax which was made worse by deep breathing and coughing. For 24 hours before admission he had been febrile and vomited everything taken by mouth. It was further noted that the patient had extensive contact with an infectious case of far-advanced pulmonary tuberculosis. This contact was terminated five months prior to the onset of our patient's illness.

This orphaned boy and his grandmother live alone in a four-room house in Louisville. The death of the parents was non-contributory to the present illness. In June of 1955, a tuberculin skin test on the patient was negative.

Physical Examination

At the time of admission the child was a fairly well developed, but poorly nourished (66 lbs. — 10th percentile), Negro male. He appeared acutely ill and was moderately dehydrated, but was in no acute distress. Temperature 103 degrees (F) orally; pulse 120 per minute; respirations 20 per minute; blood pressure 106/60. Other significant positive physical findings were limited to the thorax. In the left lower lung field there was splinting, inspiratory lag, vocal and tactile fremitus, and dullness to percussion. Breath sounds were faint over the area of dullness.

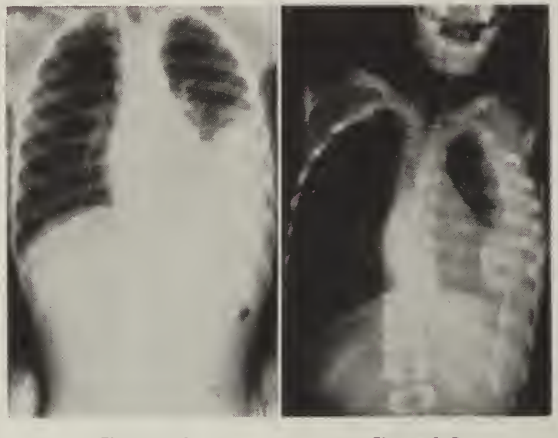


Figure 1-A Figure 1-B

Figure 1-A—PA view before therapy; Figure 1-B—Left lateral decubitus before therapy.

Laboratory Findings

Initial laboratory findings were:

Urinalysis within normal limits.

Sickle cell preparation negative.

Hemogram showed a hemoglobin of 10.0 gm. %.

WBC 12, 100 with 62 polymorphonuclear forms and 38% lymphocytes.

Chest x-rays revealed a moderate pleural effusion on the left. Some parenchymal infiltration was also seen in the left lower lobe. A left lateral decubitus film showed a definite fluid level, further confirming the suspicion of effusion. (Figure 1)

L. G. H. No. 226604

A diagnostic thoracentesis was performed and 20 ml. of pale, yellow, very slightly turbid fluid was removed. There were 3,800 white cells per cubic mm., of which 62 per cent were lymphocytes. Routine smears and cultures were negative. Acid fast stains were negative and to date no organisms have grown on cultures for tuberculosis.

Routine tuberculin (5 Tuberculin Units of PPD) and histoplasmin (0. 1 cc of 1:100 dilution) skin tests were applied on admission. The tuberculin test measured 15 mm. induration at 48 hours; the histoplasmin skin was negative.

Treatment for active primary tuberculosis with pleural effusion was started at the beginning of the third hospital day.
(See Table No. 1)

TABLE I

Therapy for Tuberculous Pleural Effusion

1. Isonicotinic acid hydrazide (INH), 20 milligrams/kilogram/day.
2. Para-aminosalicylic acid, 300 milligrams/kilogram/day.
3. Prednisone, 1 milligram/kilogram/day.
4. Ascorbic acid, 100 milligrams, b. i. d.
5. A high protein, high calorie diet.

The Social Service Department and the Tuberculosis Epidemiological Unit of the Public Health Department completed a survey of the family and intimate contacts. No infectious tuberculosis was found among the contacts except for the cousin hospitalized in a tuberculosis sanatorium.

Clinical Course

The patient became afebrile and asymptomatic during the first day of therapy. There has been no recurrence of his symptoms to date. Clinical examination and x-ray revealed marked lessening of the effusion by the third day of therapy. (Figure 2) By the 13th day of treatment the only finding was a slightly thickened pleura over the base of the left lung, which has persisted to the present time. (Figure 3)

During the remainder of the hospitalization he remained asymptomatic and gained 5 pounds. He was discharged on October 22, 1959, on his 24th hospital day. During the next month at home he gained 20 pounds. This weight gain was partially ascribed to the steroid treatment and he became somewhat moon-faced. Prednisone dosage was gradually decreased and was discontinued on November 30. He is to be kept on INH and PAS for at least a year and will be followed by the Tuberculosis Clinic.



Figure 2
Third day of therapy.



Figure 3
13th day of therapy.

Case Discussion

W. C. Adams, M. D., Assistant Professor of Child Health

This child has the classical findings of active primary tuberculosis with pleural effusion. The diagnostic value of the history of the routine tuberculin testing is self-evident. In retrospect, the appropriate family survey and follow-up performed at the time this patient's cousin was hospitalized with infectious tuberculosis might have revealed this child's active primary disease. Had this been the case, INH and PASA therapy might have prevented development of an effusion. Recent studies have confirmed the effectiveness of INH therapy of active primary tuberculosis to prevent post-primary complications. Tuberculous pleural effusion is the result of the sensitization of the pleura to tuberculoprotein with resultant exudate. INH is the specific treatment for M. tuberculosis. (See Table No. 1) This drug is used in combination with PASA in order to:

1. Reduce the emergence of resistant organisms.

2. Provide a higher body level of metabolically active INH.

Since hypersensitivity plays such an important role in tuberculous effusion, the use of steroids appears rational when the tuberculous infection is being treated simultaneously with

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ARISTOGESIC is particularly effective for relief of chronic — but less severe — pain of rheumatic origin. ARISTOGESIC combines the anti-inflammatory effects of ARISTOCORT® Triamcinolone with the analgesic action of salicylamide, a highly potent salicylate. Dosage requirements for ARISTOGESIC are substantially lower than generally required for each agent alone. The exceptionally wide latitude of dosage adjustment with ARISTOGESIC permits well-tolerated therapy for long periods of time with fewer side effects.

Indications: Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis, and certain muscular strains.

Dosage: Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

Precautions: All precautions and contraindications traditional to corticosteroid therapy should be observed. The amount of drug used should be carefully adjusted to the lowest dosage which will suppress symptoms. Discontinuance of therapy must be carried out gradually after patients have been on steroids for prolonged periods.

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(Continued from Page 201)

the appropriate antimicrobial agent. Prednisone was used with the above rationale. It was hoped to enhance the resorption of the effusion and to prevent pleural fibrosis. Uncontrolled tuberculous effusion can result in pleural thickening with subsequent decreased pulmonary ventilation and scoliosis.

Therapy with INH and PASA will be continued for at least one year. A ferric chloride test for urine salicylates will be performed on follow-up visits during this year of treatment to be sure that the medications are being taken.

The lessening of fever and lethargy and increased appetite, noted in this case, may have been associated with the steroid therapy. The patient received Prednisone for 28 days. After prolonged steroid therapy, it is advisable to stimulate the adrenals with adernal corticotropic hormone (ACTH) during the last few days of steroid treatment.

The patient was permitted full activity at home while receiving steroids to reduce the potential of superimposed bacterial infections. Since there was no evidence that this child's tuberculosis was infectious, as soon as the steroid therapy was discontinued he was allowed full activity at school and play.

A. J. Steigman, M. D., Professor of Child Health

The use of steroids for tuberculous effusion has been emphasized. Steroid therapy has been very useful in the treatment of many types of tuberculosis, particularly in those infections involving serous surfaces and the central nervous system. Steroids are of particular importance in the treatment of tuberculous meningitis.

Doctor Adams mentioned the possibility of scoliosis and decreased pulmonary ventilation. This complication will be checked for periodically by measuring the patient's vital capacity. This determination of his respiratory capacity will be continued throughout his active therapy and convalescence. Appropriate physical therapy will be introduced at the first indication of any change in his vital capacity indicating complications from his tuberculosis with effusion.

During the same period of time, the tuberculosis status of the other members of his family will be carefully observed to insure appropriate therapy if warranted. This patient is approaching adolescence, during which time he may be subject to endogenous re-infection from his primary lesion. It is hoped that the INH and PASA therapy for the tuberculous effusion will reduce the potential from endogenous re-infection. However, the child must be observed at regular intervals for any such complications. Although endogenous re-infection can occur any time, it is most frequent during adolescence or old age. Unless an unexpected complication occurs, this child should continue to be treated like any normal, healthy, growing 11-year-old boy.

If you once forfeit the confidence of your fellow citizens, you can never regain their respect and esteem. It is true that you may fool all of the people some of the time; you can even fool some of the people all of the time; but you can't fool all of the people all of the time.

—Abraham Lincoln

SPECIAL ARTICLES

Report Of the House of Delegates Of the AMA - 13th Clinical Meeting, Dec. 1-4, 1959, Dallas, Texas

THE Clinical Meeting of the American Medical Association was held in Dallas, Texas, December 1-4, 1959. Those present representing Kentucky were: Vincent Pierce, M.D., and Robert C. Long, M.D., Delegates; Vernon Pace, M.D., and George Archer, M.D., alternate delegates; and Mr. Joseph Sanford, executive secretary of the KSMA. This report will not cover all of the actions taken by the House of Delegates but will cover the important actions adopted by the House with special reference to any matters that are of particular interest to the physicians of Kentucky.

Louis M. Orr, M.D., of Orlando, Fla., AMA President, spoke at the opening session of the House on Tuesday, December 1. Doctor Orr gave one of the finest presidential addresses that we have heard. He is a dedicated and tireless worker for American medicine and has already proven himself one of medicine's best spokesmen. While Doctor Orr discussed many topics in his address, he laid special emphasis on the Forand Bill and the growing problem of the shortage of qualified, dedicated young men and women for medicine. In regard to the Forand Bill, Doctor Orr made it abundantly clear that if or when such legislation, even in its most dilute form, is passed, the private practice of medicine as we live it today will soon be a thing of the past and in time all medical care will be federally controlled.

In this regard, your delegates wish to urge every physician of Kentucky actively to oppose the Forand Bill, not only by registering your opposition with your Congressmen and Senators but also by talking to your patients and neighbors, convincing them it is undesirable and urging them to register their opposition with their Congressmen and Senators. This is the most effective way to defeat legislation of any kind. All of us know that the quality of medical care will suffer greatly in this country if the Forand Bill or similar legislation becomes law.

In regard to the problem of getting qualified, dedicated young men and women to go into medicine, Doctor Orr listed reasons why we are not getting the numbers we once did and reminded us that programs on the national, state and local level should be undertaken if we are to continue to get the finest men and women for medicine.

The major items for business that came before the House of Delegates were (1) freedom of choice of physician; (2) relations between physicians and hospitals; (3) a scholarship program for deserving medical students and (4) relative value studies of medical services.

Freedom Of Choice

In regard to freedom of choice, the House reaffirmed the following two statements approved in Atlantic City in June, 1959: (1) "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses." (2) "Each individual should be accorded the privilege to select and change his physician at will or select his preferred system of medical care. The American Medical Association vigorously supports the right of the individual to choose between these alternatives."

However, in order to clarify and strengthen its position on the issue of freedom of choice of physician, the House also adopted this additional statement, which was submitted as a substitute admendment on the floor of the House: (3) "Less there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provide medical care must be judged on the degree to which it allows of or bridges such freedom of choice and such competition."

This is a much stronger statement concerning the relationship of medical care and freedom of choice of physician than has heretofore been adopted by the House, and your Kentucky Delegation is pleased to report that the substitute amendment as outlined in paragraph 3 above was submitted by us and, with the support of many others, this amendment was adopted by a margin of 2½ to 1.

Physician-Hospital Relations

In regard to physician-hospital relations, the House received 12 resolutions on the subject of relationship between physicians and hospitals. To resolve any

doubts about its position, the House did not act upon any of the resolutions but, instead, reaffirmed the 1951 "Guides for Conduct of Physicians in Relationships with Institutions." It also declared that "All subsequent or inconsistent actions are considered superseded."

The House also accepted recommendations that (1) The House of Delegates acknowledge the need to strengthen relationships with hospitals by action at state and local levels; (2) The Board of Trustees of the Association continue to maintain Liaison with the Board of Trustees of the American Hospital Association; (3) The Council on Medical Service review this entire problem to ascertain if there have been actions inconsistent with the 1951 Guides.

Those Guides referred to above summarize the following general principles as the basis for adjusting controversies between physicians and hospitals:

"A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

(2) Where a hospital is not selling the services of a physician the financial arrangement if any between the hospital and the physician properly may be placed upon any mutually satisfactory basis. This refers to the remuneration of a physician for teaching and research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes."

(3) "The practice of Anesthesiology, Pathology, Physical Medicine and Radiology is an interval part of the practice of medicine in the same category as the practice of surgery and internal medicine or any other designated field of medicine."

Scholarship Program

In regard to the scholarship program which would help meet the need for an increasing number of qualified physicians in the future, the House approved the creation of a special study committee which was asked to:

(1) Present a scholarship program — its development, administration and the role of the American Medical Association in fulfilling it.

(2) Ascertain the maximum to which schools could expand their student bodies while maintaining the quality of medical education.

(3) Ascertain what universities can support new medical schools with qualified students and sufficient clinical material for teaching either on a two-year or full-year basis.

(4) Investigate the securing of competent medical facilities.

(5) Investigate financing of expansion and establishment of medical schools.

(6) Investigate financing of medical education as to the most economical methods of obtaining high quality medical training.

(7) Develop methods of getting well qualified students to undertake the study of medicine.

(8) Investigate the possibility of relaxing rigid geographic restrictions on the admission of students to medical schools.

The House urged that the special committee be implemented promptly with adequate funds and staff so it may make an initial report by June, 1960.

Relative Value Studies

In regard to relative value studies, the House reaffirmed a previous policy statement, approving in principle the conducting of relative value studies by each state medical society, rather than a nation-wide study or a series of regional studies by the AMA. The House also reiterated its authorization for the Committee on Medical Practice to inform each state medical association of regional or other meetings of the purpose, scope and objectives of such studies, the steps to be followed in conducting studies, the problems which may be encountered and the manner in which the result can be applied.

The House expressed awareness of the fact that medical societies are either not interested in relative value studies or are actively opposed to them. It pointed out that some state medical associations feared that the Regional Conferences of the Committee on Medical Practices will put pressure on them to carry out such studies and that this will result in the adoption of "fixed fees."

Since the Regional Conferences are educational in nature, the House said it remains for each state or county medical association to accept or reject the idea of a study in its area.

The House expressed awarenes of the fact that this is still a controversial matter. However, it commended the Committee on Medical Practices for its efforts to carry out the instruction of the House and it urged the committee to continue its educational work.

This is particularly appropriate for us in Kentucky, for relative value studies are being carried out in this state at the present time.

Miscellaneous Actions

In considering 44 resolutions in a large volume of annual supplementary and special reports, the House also:

Learned that the AMA Board of Trustees has appointed a Liaison Committee to meet with a similar committee of the American Osteopathic Association to consider matters of common concern;

Emphasized that local medical societies should insure that no member violates ethical tradition as they relate to ownership of pharmacies or stock in pharmaceutical companies;

Approved the plan of the Committee on Medical Rating of Physical Impairment to publish its new Guide on the Cardio-Vascular System in the AMA Journal;

Called for investigation of the need, desirability

(Continued on Page 247)

EDITORIALS

Farm and Home Safety

OUR friends, the farmers, through the Kentucky Farm Safety Committee, are asking our assistance in reducing the number of farm and home accidents. This is very fine because, in reality, we are interested at least as much if not more than anyone else. On many occasions the physician has an opportunity to preach safety and safety measures on the farm, in the home and many other places.

The Kentucky Farm Safety Committee has a definite program which consists of stressing a different type of accident each month. This month they are interested in and disseminating information on accidents caused by electricity. They wish us to carry to the home the information that electricity is extremely dangerous when used without caution, and they list the following precautions:

1. Be sure not to overload the circuits.
2. Always disconnect electrical appliances when not in use.
3. Never plug or unplug electrical appliances while the hands are wet.
4. Keep children away from electrical appliances and outlets.
5. Start the New Year right by practicing safety in the home and on the farm.

Any assistance to our friends, I am sure, will be appreciated and we will be rewarded for our efforts.

Delmas M. Clardy, M.D., Chairman
Advisory Committee on Public Health

Kentucky Medicine In The Present Decade

AT the close of last year and the beginning of this, the press was unusually prolific in articles reviewing the past decade and prophesying what we could expect in the 10 years to come. The Courier-Journal on January 1, 1960, carried an article of this type prepared by Mr. Robert P. Clark. Now, we in Louisville generally regard Mr. Clark as possessing a wide and usually sympathetic understanding of medicine and its present problems. His clearness of style and brevity commend his writings to a very large Kentuckiana audience. His observations, therefore, merit some review and comments.

He states in the beginning that the signs are unmistakable that the 1960's will bring America closer to government medicine than ever before. The three clear indications of this trend are: (a) probability of the passage of Forand type legislation—free hospital and medical care to Social Security recipients, (b) the extension of the Government's Medicare Program for dependents of military personnel, (c) the probable implementation by our Legislature this year of an indigent medical care program in Kentucky.

It is very interesting to analyse the attitude of organized medicine in Kentucky to these

three separate and distinct facets of government medicine. For good and sufficient reasons we oppose the Forand type of legislation and state that under the system of private practice we can accomplish better care and at less cost than is proposed under Federal subsidy. The medicare program we have come to accept with considerable reservation and some general organized opposition. We call it "not too bad," although a distinct encroachment by the Government upon private enterprise. Most State Medical Societies have cooperated with this plan. We as a State Medical Association vigorously endorse the indigent Medical Care Plan in Kentucky, because it is good for those unfortunate citizens of our Commonwealth who cannot obtain or afford adequate medical care.

Third Party Medicine

Mr. Clark predicts that during 1960 the closed panel practice fostered by labor groups and typified by the United Mine Workers activity in Eastern Kentucky will be extended. Kentucky undoubtedly has been used as a test area or proving ground for this type of practice. There has been and, naturally enough, remains considerable opposition on the part of private practitioners in the State to the present operation of this system. Whether it expands greatly beyond its present activity or not, it is to be hoped that more equitable relations between this segment of practice and the private practitioners of medicine will be accomplished. Efforts toward this end have not been fruitless and if patience and understanding are practiced by both parties concerned an equitable agreement will undoubtedly be accomplished.

It is predicted that appeals of administrative medicine, Public Health, teaching and research, industrial and government medicine will be very attractive to the graduating physicians of the present decade. It is estimated that in spite of the increased number of medical graduates, fewer doctors in relation to the whole profession will be in private practice at the end of this decade than at present. It is to be hoped that the above prediction will prove incorrect, especially as far as Kentucky is concerned. We are well behind the national average in private practicing physicians by 100,000 population, and it is to be hoped that in the coming decade this proportion will improve rather than get worse. With the operation of the new Medical Center in Lexington and the present capacity of the Medical School in Louisville we should within the next five years be graduating 175 physicians a year instead of 100. During the past 10 years, $100,000,000 has been spent in Kentucky for the establishment of new hospitals, clinics and health centers and the enlargement and improvement of the existing facilities. It is anticipated that in the present decade we will see greater expansion for this purpose than we have had previously.

Improvement in transportation and the determined effort of our present administration to continue to elevate the economic status of our citizens certainly should provide a more attractive lure to the private practicing physician than he has ever before experienced in Kentucky. We trust, therefore, that of the increased output of physicians we will be able to retain in private practice in Kentucky an appreciably larger proportion than we have in the past.

Graduates Will Increase

During the past year several different national agencies have estimated that in 1975 there should be graduated in the United States between ten and eleven thousand physicians each year. Up to the present time the figure annually has never exceeded 7,000. According to these estimates we are, therefore, faced with a necessity of a 30 per cent or more increase in the output of physicians during the next 10 or 15 years. Whether this can be accomplished remains to be seen. Confronted with these estimates, however, we should be able to take a considerable degree of comfort in the fact that we in Kentucky have already extended ourselves the limit and are now prepared to carry our portion of this increased load.

We as physicians have an obligation to seek out and encourage young men and women who are fitted by natural endowments and temperament to undertake the study of medicine. We need more physicians. Our quota will presently be 175 freshman medical students each year. As many as possible of these candidates should be recruited from Kentucky youth. The best way to accomplish this is for every physician to consider himself a personal agent to seek

out and encourage both high school and college students who show the greatest promise for medicine.

The present decade then is filled with some ominous warnings and with a considerable element of bright hope and encouragement. Undoubtedly, encroachments of government medicine will continue and many of these methods will be undesirable. We will continue to evaluate and choose as wisely as we can and we will continue, as have our predecessors of the past three decades, to defend our position of individuality, free choice of physician, fee for service and other freedoms which we regard as our democratic rights as well as the best for those whom we serve.

On the morning of January 1, 1960, Mr. H. Roe Bartle, distinguished Mayor of Kansas City, addressed the annual New Year convocation of the Louisville Chamber of Commerce. Stimulating and entertaining as was his unusual address, he clearly presented one thesis: Improvement and reform in government as well as in all other activities comes not from the top but from the bottom; first the individual, next the community in which he lives —his constituency, his party, his state—must believe and practice reform. The sumtotal of communities and states so committed can lead to an improvement that is sound and lasting.

As individual physicians and as constituents of county and state units we may well adopt Mr. Bartle's philosophy. A new decade is underway. It lies almost entirely ahead. We must choose from day to day, year to year, what is good and constructive and lasting; if we choose well and work intelligently and industriously to chart our course thereby, we and our successors 10 years from now will be happy and proud of the results.

Sam A. Overstreet, M.D.

For Those Who Plan Ahead . . .

AMA Annual Meeting—June 13-17

Miami Beach, Fla.

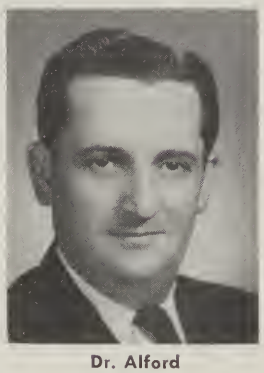
KSMA Annual Meeting—Sept. 20-22

Columbia Auditorium, Louisville, Ky.

ORGANIZATION SECTION

Nationally Known Speakers, Congressional Committee 'Hearing' Slated For 10th County Society Officers Conference

A widely known physician-Congressman, the president of the National Conference of Blue Shield Plans, a public relations expert and two AMA authorities on medical legislation will headline the program of the 10th Annual County Society Officers Conference set for Thursday, March 31, at Gabe's Restaurant, Owensboro.



Dr. Alford

Highlighting the afternoon session will be a simulated Congressional Committee hearing on the Forand Bill. C. Joseph Stetler, Chicago, director of the American Medical Association's Law Division, will be the moderator, and prominent physicians on the AMA and state levels will take the roles of participants in the highly publicized hearing.

Featured speaker of the day will be Dale Alford, M.D., Congressman from Little Rock, Ark., who will address the luncheon meeting on "The Legislative Challenge That Medicine Faces."

Doctor Alford, a graduate of the University of Arkansas School of Medicine, took postgraduate training in ophthalmology at the University of Illinois Eye and Ear Infirmary, Chicago. During World War II, he served five years in the Army Medical Corps, a part of the time in the European Theater. After the war he practiced for two years in Atlanta, Ga., where he was on the teaching staff of Emory University. He returned home to Little Rock in 1948, since when he has been in private practice there. Active in organized medicine and a civic leader, Doctor Alford was elected to the 86th Congress in 1958.

Gerald J. Skibbins, Princeton, N. J., research executive of Opinion Research Corporation, is scheduled as the first guest speaker at the morning session. His topic will be: "How Changing Public Attitudes Affect Medicine."

A writer and lecturer on sales management, theory of government, economics and philosophy, Mr. Skibbins specializes in major attitude research projects on medical public relations, political issues and marketing strategy. His special interest is in devising executive control systems for superior management problem-solving efforts of the future.

"Quo Vadis," which translated means "Whither Goest Thou?" is the title announced by F. L. Feierabend, M.D., Kansas City, Mo., for his address before the conference Thursday morning. Doctor Feierabend, a co-founder of the National Conference of Blue Shield Plans, is its present president. He was the founder of and a past president of the Kansas City Blue Shield.

The other two guest speakers are no strangers to Kentucky physicians. Ernest B. Howard, M.D., Chicago, assistant executive vice-president of the American Medical Association, who is booked for an address on "Effectively Meeting Our Adversaries," spoke at the 1959 society officers conference in Lexington. Mr. Stetler, who will act as moderator for the Congressional Committee hearing, was a participant in the 1957 conference, also in Lexington.

An executive with the AMA since 1948, Doctor Howard has a background of wide experience in the field of medicine. He was graduated from the Boston University Medical School in 1936, and three years later the Harvard School of Public Health conferred upon him the Master of Public Health degree. He headed a health mission to Peru for the U.S. State Department in 1946, for which he received Peru's highest decoration, the Order of Sol.

Mr. Stetler has long been a student of health legislation. A former secretary to the AMA Committee on Legislation, he has also worked with the Civil Service Commission, Social Security Administration and the War Claims Commission. Mr. Stetler received an LL.M. degree from Catholic University, Washington, in 1940 and served four years in the U.S. Army in World War II.

A complete program of the county society officers conference appears on the opposite page.

The President Says . . .

KSMA President Irvin Abell, Jr., M.D., Louisville, warmly urges all county medical societies to encourage their officers, committees and members to plan to attend this important conference.

It is requested that those counties which have not sent the names of their officers and committee personnel to KSMA Headquarters Officers, please do so at the earliest date possible.

Program

Tenth Annual County Society Officers Conference

Gabe's Restaurant, Owensboro **Thursday, March 31, 1960**

MORNING SESSION

Irvin Abell, Jr., M.D., Louisville, President,
Kentucky State Medical Association, Presiding

9:00 a.m. **Registration**

9:45 a.m. **Coffee Call**

10:00 a.m. **Call to Order and Announcements,** Dr. Abell
Invocation, Dr. Jess Moody, pastor of First Baptist Church, Owensboro
Welcome, Jack C. Blackstone, M.D., Owensboro, president of Daviess County Medical Society
Remarks from the Secretary, Woodford B. Troutman, M.D., Louisville

10:15 a.m. **"How Changing Public Attitudes Affect Medicine"**
Gerald J. Skibbins, Princeton, N. J., research executive of Opinion Research Corporation

10:40 a.m. **"Quo Vadis"**
F. L. Feierabend, M.D., Kansas City, Mo., president of the National Conference of Blue Shield Plans

11:05 a.m. **Coffee Break**

11:15 a.m. **"Effectively Meeting Our Adversaries"**
Ernest B. Howard, M.D., Chicago, assistant executive vice-president of AMA

LUNCHEON SESSION

Irvin Abell, Jr., M.D., Presiding

12:30 p.m. **"The Legislative Challenge That Medicine Faces"**
Dale Alford, M.D., Congressman from Little Rock, Ark.

AFTERNOON SESSION

Richard G. Elliott, M.D., Lexington, President-Elect,
Kentucky State Medical Association, Presiding

1:45 p.m. **Simulated CONGRESSIONAL COMMITTEE Hearing**
(Considering the Forand Bill—HR 4700)
Moderator—C. Joseph Stetler, Chicago, Director, AMA Law Division
Other Participants—Ernest B. Howard, M.D., Chicago; George Archer, M.D., Prestonsburg; Wyatt Norvell, M.D., New Castle; O. Leon Higdon, M.D., Paducah, and others.

(A Surprise)



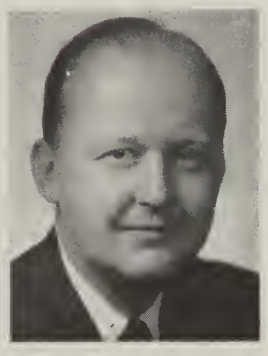
Mr. Skibbins



Dr. Feierabend



Dr. Howard



Mr. Stetler

Committees Hard At Work On Plans For 1960 Annual Meeting

Committees are actively at work on plans for the 1960 Annual Meeting of KSMA, scheduled in Louisville on September 20, 21 and 22, announces Irvin Abell, Jr., M.D., Louisville, KSMA president and chairman of the Committee on Scientific Assembly and Arrangements. It will be known as the Charles H. Todd Memorial Meeting.

The specialty groups will be divided again this year, with six meeting simultaneously on Tuesday afternoon and seven on Thursday morning. This arrangement, inaugurated in 1959, met with the approval of attending physicians as it permitted attendance at more sessions than in former years when all the specialty programs were held on the same day.

With 1960 marking a new decade, reunions for graduates of the University of Louisville School of Medicine will be held for the classes of the decade years and the years ending in 5, according to George McAuliffe, M.D., Louisville, president of the U. of L. Medical Alumni.



Dr. Mattingly



Dr. Seyle

Heart Symposium March 9-10 Books 12 Speakers

Eleven medical schools of the United States and Canada and the Mayo Foundation will be represented by speakers at the Sixth Annual Symposium on Cardiovascular Diseases to be held March 9 and 10 at the Brown Hotel, Louisville. The program is sponsored by the Heart Association of Louisville and Jefferson County and the University of Louisville School of Medicine.

Scheduled as the dinner speaker on March 9 is a special lecturer in cardiology, Thomas W. Mattingly, M.D., Washington, D. C., who is also booked for a scientific presentation on March 10. His dinner address on "The Highway Accident As a Common Cause of Trauma to the Heart and Great Vessels" will be open to the public.

Doctor Mattingly is director of medical education at Washington Hospital Center, consultant in cardiology at Walter Reed Army Hospital and Children's Hospital, Washington, and clinical professor of medicine at Georgetown University School of Medicine. A retired brigadier general of the Medical Corps, U. S. Army, he is active in numerous medical groups.

A well-known guest speaker from Canada, Hans Selye, M.D., will appear on the program March 10. Doctor Selye is professor and director of the Institut de Medecine et de Chirurgie Experimentales, Universite de Montreal.

For a complete program of the two-day symposium, turn to Page 244 of this Journal.

You Are Urged to Register to Vote In Primary Before Mar. 26

The KSMA Legislative Committee urges all KSMA members, their families and employees to register to vote in the May primary before the March 26 deadline. The present law states that the primary will be held the first Tuesday following the fourth Monday in May.

As pointed out by George Archer, M.D., Prestonsburg, and Wyatt Norvell, M.D., New Castle, KSMA Legislative co-chairmen, many important national and local offices will be filled this year. They urged all KSMA members to take advantage of their voting privileges.

While bills are being introduced in the current session of the Legislature which may cause some change in the primary date, the chances for enactment, as The Journal meets its deadline for this issue, are not known. The Legislative chairmen feel, in order to be on the safe side, all should register before March 26 as provided by the present law.

Health Care Is Fourth Necessity, Says Blue Cross Head

Health care has become a necessity of life, along with the traditional trio of food, clothing and shelter. So said James E. "Jeb" Stuart, New York, president of the Blue Cross Associations of America, in addressing the Jefferson County Medical Society in Louisville on December 21.

The right of people who are ill to have hospital or medical care—whether or not they can pay for it—is a recognized fact today, he pointed out. "We prefer to do this job through voluntary means" rather than through Government means, he added.

One-third of Kentucky families will get a hospital bill in 1960, Mr. Stuart predicted.

Blue Cross, a non-profit plan sponsored by hospitals, uses 94½ cents out of every dollar taken in for actual medical care, its president said.

Seven Frankfort M.D.'s Honored

Seven Frankfort physicians have received awards for distinguished service to the King's Daughters' Hospital. Recognized for at least 22 years of service on the active staff were: Joseph Barr, M.D.; B. B. Baughman, M.D.; W. P. Blackburn, M.D.; L. L. Cull, M.D.; Edward K. Martin, M.D.; Grace Snyder, M.D., and W. S. Snyder, Jr., M.D. Each of the group received a framed certificate at a silver tea given by the Silent Workers Circle which operates the Frankfort hospital.

Dr. Massie Is New President Of Southern Surgical

The second signal honor within three months came to Francis Massie, M.D., Lexington, with his election as president of the Southern Surgical Association at the group's annual meeting at the Homestead in Hot Springs, Va., on December 10.



Dr. Massie

Last September, Doctor Massie received the KSMA's Distinguished Service Medal for 1959.

Southern Surgical — a select society limited to 225 surgeon-members — has had four former presidents from Kentucky: Charles Vance, M.D., Lexington; the late Irvin Abell, M.D., Louisville; the late Fred Rankin, M.D., Lexington, and the late Dan Elkin, M.D., Lancaster.

Doctor Massie, who heads the staff of the Lexington Clinic, was one of the founders of the Kentucky Surgical Society, served as its secretary-treasurer the first seven years, and is now chairman of its Council. He is the present co-chairman of the KSMA McDowell Home Committee.

After his term as president of the Southern Surgical Association, he will serve as a member of its Council for four years.

Surgeons Elect Dr. Atherton

Lytle Atherton, M.D., Louisville, is the new president of the Louisville Surgical Society, succeeding C. Melvin Bernhard, M.D. Other officers elected by the society include Henry S. Collier, M.D., vice-president, and Walter Hume, Jr., M.D., and Ludwig Segerberg, M.D., executive committee.

KSMA Members Participate In Social Security Seminars

KSMA members have been participating with the Social Security District Office in a series of seminars on disability, designed to provide information of benefit both to the SS staff and members of the profession.

According to J. Duffy Hancock, M.D., Louisville, chairman of the National Advisory Committee to the Social Security Administration and Disability, this is the first undertaking of its kind on such a broad scale in the nation.

Participating in the program have been A. S. Barnes, M.D.; Walter S. Coe, M.D.; Rex O. McMorris, M.D.; David H. Neustadt, M.D.; William P. Peak, M.D., and Carrol Witten, M.D., all Louisville physicians.

Such groups as the American Heart Association, the American Cancer Society and the Arthritis and Rheumatism Foundation have conducted panels. Future seminars will cover psychiatric and tuberculosis care, etc.

Doctor Hancock said that Hugh A. McNary, Jr., Social Security district manager, had explained that this is "not an attempt to make diagnosticians out of the staff members, but to give them a broad background that will enable them to do a more effective job in interviewing applicants for disability, remembering at all times the medical evidence is passed on by doctors." In this way, the amount of abuse is reduced.

Specialty Groups List Meetings

The Kentucky and Indiana Chapters of the American College of Surgeons will meet with the Kentucky and Indiana anesthesiologists at French Lick, Ind., on June 17-18, 1960, announces William T. Rumage, Jr., M.D., Louisville, secretary of the Kentucky Chapter.

The Kentucky Surgical Society will hold its 1960 annual meeting on Saturday, May 14, at the Sheraton Hotel in French Lick, Ind., according to C. M. Bernhard, M.D., Louisville, secretary-treasurer.

The Kentucky Obstetric and Gynecologic Society has scheduled its annual meeting for May 12-14 at the Campbell House in Lexington, it is announced by Robert Monroe, M.D., Louisville, president, and Douglas M. Haynes, M.D., Louisville, secretary-treasurer. Guest speaker will be Edith L. Potter, M.D., of the University of Chicago.

Dr. Denham Resigns Health Post

Mitchell B. Denham, M.D., Maysville, who took office January 1 as a Representative in the Kentucky General Assembly, resigned in December from the Mason County Board of Health after serving 12 years as a member. In his letter of resignation, he cited some of the board's accomplishments in which he had had a hand. Chief among these, the new health center was built and furnished and the health department was made self-financing.

Doctor Denham is chairman of the KSMA Committee on Rural Health and chairman of the Kentucky Rural Health Council.

Medical Radio Service Proposed

Establishment of a "Medical Emergency Radio Service" has been proposed by the Federal Communications Commission, with eligibility limited to physicians, hospitals and ambulance services. The Commission proposes to allocate 13 frequencies in the 152-162 Mc band and 4 frequencies in the 42-50 Mc band for the new service.

The American Medical Association petitioned the FCC for such a service on October 8, 1958. At that time, the AMA expressed its concern about the need for changes in the rules of the Commission to provide a radio service for use not only in emergencies that arise in the routine practice of medicine, but also for use in mobilizing physicians during extreme natonal, regional or local emergencies.

Crippled Children Commission Announces Services

Limited funds for heart surgery for children suffering from congenital heart disease have been made available until July 1 to the Kentucky Crippled Children Commission by the Children's Bureau, according to the Commission's medical director, Marjorie K. Smith, M.D. To receive this service, a child must be from an indigent family or a family able to pay only a part of the cost. Surgery is done at the two special centers set up by the Children's Bureau in Maryland and Minnesota.

The Kentucky Commission regularly offers services to children whose parents are indigent or unable to pay total amount of care. Treatment is provided for types of crippling conditions, such as polio, congenital deformities, cerebral palsy, tuberculosis of the bone, osteomyelitis, scoliosis, flat feet, rickets and injuries causing orthopedic defects. It also provides plastic surgery in such cases as burns, cleft lips and cleft palates. Regular clinics are held in centers in Louisville, Lexington, Covington, Paducah and Ashland. Many field clinics are scheduled during the spring, summer and fall months.

Referrals should be made to the Louisville office, 1405 East Burnett, Louisville 17, Ky.

Eight Councilor Districts Set Spring Meetings

Eight Councilor Districts have scheduled spring meetings, at which KSMA president, Irvin Abell, Jr., M.D., Louisville, will speak.

The dates and meeting places have been announced by the District Councilors as follows:

Eighth District—April 7, at Covington. Norman Adair, M.D., Covington, Councilor.

Ninth and Eleventh Districts—April 14, joint meeting at Paris. J. M. Stevenson, M.D., Brooksville, Councilor of Ninth District, and Joe M. Bush, M.D., Mt. Sterling, Councilor of Eleventh District.

Thirteenth District—April 21, at Henry Clay Hotel, Ashland. Charles B. Johnson, M.D., Russell, Councilor.

Twelfth and Fifteenth Districts—May 5, joint session at duPont Lodge, Cumberland Falls. Thomas O. Meredith, M.D., Harrodsburg, Councilor of Twelfth District, and Keith P. Smith, M.D., Corbin, Councilor of Fifteenth District.

Fourth and Sixth Districts—June 9, joint meeting at Mammoth Cave. Dixie E. Snider, M.D., Springfield, Councilor of Fourth District, and John P. Glenn, M.D. Russellville, Councilor of Sixth District.

The Journal will carry full details of each meeting in future issues.

Jefferson County Society Elects Dr. Costigan

Daniel G. Costigan, M.D., Louisville, was elected president of the Jefferson County Medical Society for 1961 at the group's annual meeting held at the Medical Arts Building, Louisville, on January 18.

George W. Pedigo, M.D., Louisville, took over the presidency for 1960. He succeeds Foster D. Coleman, M.D., Louisville.

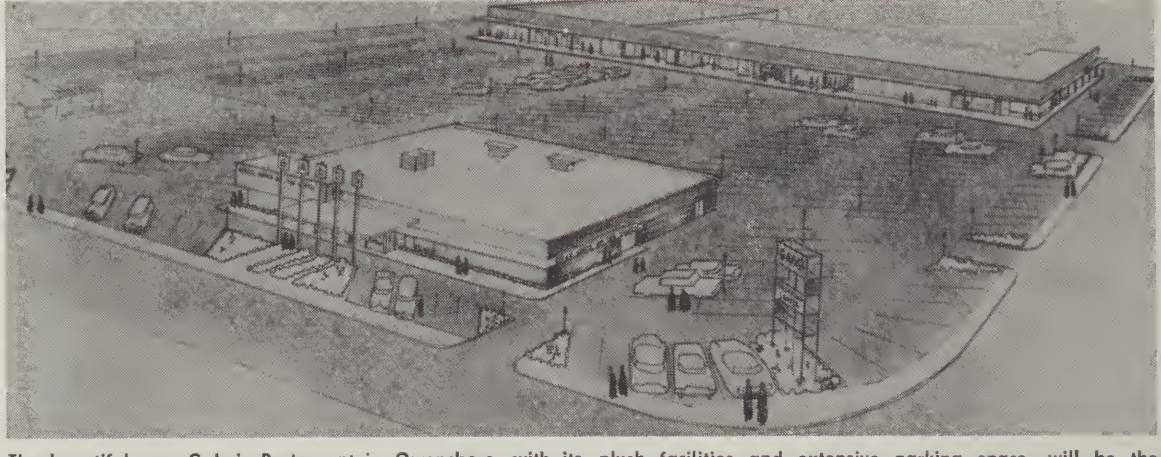
Other officers elected were: Frank M. Gaines, Jr., M.D., first vice-president; Louis Mitzlaff, M.D., second vice-president; William E. Pugh, M.D., secretary; Walter I. Hume, Jr., M.D., treasurer, and J. Ray Bryant, M.D., and Grover B. Sanders, M.D., judicial-council members. All are Louisville physicians.

KAGP Annual Meeting May 11-13

The Kentucky Academy of General Practice has announced May 11-13 as the date for its ninth annual meeting to be held at the Kentucky Hotel in Louisville. Eleven scientific papers are tentatively scheduled for presentation on the program, which is accepted for 10 hours, Category I credit.

The meeting is in charge of the group's Committee on Scientific Assembly, of which James W. Davis, M.D., Louisville, is chairman.

Site of the 10th Annual County Society Officers Conference Mar. 31



The beautiful new Gabe's Restaurant in Owensboro, with its plush facilities and extensive parking space, will be the scene of the 10th Annual County Society Officers Conference on March 31. The restaurant is located at 18th and Triplett.

Digest of Minutes of Meeting of The KSMA Council—December 17, 1959*

The first order of business was the filling of a vacancy on the Council from the Tenth Councilor District—occasioned by the election of the incumbent Councilor Richard G. Elliott, M.D., as president-elect. In compliance with the bylaws, the name of Douglas E. Scott, M.D., Lexington, was presented as a nominee from the delegates of that district to serve as councilor until the next meeting of the House of Delegates. His election was unanimous.

The president, the secretary, and the AMA delegate gave their reports in that order. (For a written report of the AMA delegate of the interim meeting in Dallas on December 1-4, see Page 205 of this issue of the Journal.)

Action On Annual Meeting

The Council then considered and adopted two recommendations of the KSMA Committee on Scientific Assembly and Arrangements. The first recommendation called for changing the meeting place of the reference committees, Tuesday afternoon, September 20, during the 1960 Annual Meeting, from the basement of the Columbia Auditorium to the air-conditioned Sunday School building of the First Christian Church adjacent to the Auditorium. The second recommendation asked that no meetings be held on Wednesday, the second day of the Annual Meeting, that would conflict with the KSMA President's Luncheon or the important House of Delegates final session which begins with a dinner meeting that evening. The Council agreed to support the University of Louisville Alumni Association if a luncheon or dinner is planned on Thursday during the Annual Meeting.

The Council authorized the mailing of a letter to all members of KSMA over the signature of the president and chairman of the Council as voted by the House of Delegates. Purpose of the letter was to explain certain information that the House of Delegates had asked the Blue Shield to obtain on its claim forms.

The Council then replaced certain vacancies that had developed in the Council-appointed committees and heard reports of the district grievance committees.

The Association's counsel, Mr. E. Gaines Davis, Jr., then reported on correspondence he had carried on with a staff member of the UMWA and received further instructions from the Council in the matter.

It was explained to the Council that the four-year term of office of Carl Fortune, M.D., Lexington, on the State Board of Health expired on December 31, and that the statutes provided that the Council of KSMA would recommend three names from which the Governor would appoint one to fill the vacancy. The Council voted to submit the following three names to Governor Bert Combs: Carl Fortune, M.D., Lexington; William J. Temple, M.D., Covington, and Oscar Miller, M.D., Louisville.

Legislative Recommendations

George Archer, M.D., Prestonsburg, co-chairman of the KSMA Legislative Committee, was called on to present the recommendation of that committee. The Council voted to accept the recommendation that at least two men from each Congressional District plan to attend the KSMA dinner honoring Kentucky's Congressmen and Senators in Washington, February 25.

Proposed changes in the Indigent Care Bill, which was to be introduced in the 1960 General Assembly by the Council on Allied Medical Services, were explained by Mr. Grogan and approved. Mr. Grogan also explained the Legislative Committee's proposal for a Cancer Quackery Bill, and this recommendation was accepted.

The recommendation that the Quick Cremation Bill, as explained, be introduced in the Legislature was approved. Also, the recommendation that the Workman's Compensation limit be increased from $2,500 to $5,000 was approved. In addition, the Council gave the go signal to proposed amendments that were designed to give certain authority to the local county health boards.

The Legislative Committee's recommendation that the request of the State Dental Association, which called for the addition of one member — a dentist — to the State Board of Health, and the addition of a dental member to each county board of health be rejected, was discussed at much length. The Council had also received a delegation of top officials of the dental association who presented the matter for the dental association earlier in the afternoon. When the question was put, the Legislative Committee's recommendation was rejected and the Council voted to support legislation which would allow an additional member, a dentist, on the State Board, and an additional dental member on each county board.

The Council also voted to authorize the Legislative Committee in compliance with the action of the House of Delegates to support the Constitutional Convention.

It was explained to the Council that the Legislative co-chairmen would, in the pursuance of their duty, make numerous phone calls. The recommendation that telephone credit cards be issued the Legislative co-chairmen, with the understanding that records of each call would be kept, was approved.

Public Information and Service

The recommendations of the Committee on Public Information and Service to the Council were presented by the KSMA executive assistant. The first recommendation called for the approving of the American Medical Assistants Association by the

* *As authorized by the 1956 session of the House of Delegates, the Journal is presenting a digest of the December 17, 1959, meeting of the KSMA Council.*

Council. After discussion, the Council authorized the chairman to appoint a committee of three to look further into this matter. The Council then approved the recommendation that the director of field services offer a public relations course for physicians' assistants similar to the one that the Committee offered several years ago.

The next recommendation dealt with the request that the Association offer a model application form for county medical society use. The form was presented and accepted. It was also explained to the Council that a county medical society had asked for a suggested list of activities for use by county medical society officers. The list proposed by the Committee was approved.

The recommendation of the Committee on Public Information and Service suggesting a survey be made to learn the amount of free medical care and charitable work that was being done by physicians was rejected by the Council. Proposal for KSMA's support to the practical nurse training program was explained and approved. The recommendation that KSMA cooperate with Blue Shield in holding a meeting for all interns and residents going into practice July 1 was referred to the Board of Directors of Kentucky Physicians Mutual for final action. The recommendation that more information be disseminated on the medical rider coverage offered by Kentucky Physicians Mutual was referred to the Medical Advisory Committee of the Board of Directors of Kentucky Physicians Mutual.

Stand On Health Department Move

The Council then listened to a letter from Thomas Ray, a Representative in the General Assembly from Jefferson County, asking the Association to support the drive to resist moving the offices of the State Department of Health from Louisville to Frankfort. Careful consideration was given Mr. Ray's request. The Council voted to support Mr. Ray's suggestion that a special committee be appointed by the Governor to look into the situation. The statement approved by the Council then went on to say that the Council did not feel qualified to pass on this question and that after the Governor had considered all information that it would gladly accept whatever decision the Governor made in the matter.

A brief report on the relative value survey, which the Council previously authorized be made of the opinion of the various county medical societies, was given. It was felt that the number of replies could not justify a decision at this time.

The Council then recognized Carl Cooper, M.D., who has been the Association's representative on the steering committee that has been appointed to look into the matter of organizing a health council for the State of Kentucky. It was also pointed out that Hoyt Gardner, M.D., had been asked by the chairman of the Council to attend the last organizational meeting of the Kentucky Health Council. After hearing both men, the Council voted to support the Kentucky Health Council as long as it lived by the bylaws, as proposed, and authorized the chairman to appoint a committee composed of Doctor Cooper, Doctor Gardner and other physicians to represent the Association and also authorized the payment of dues levied by the Council.

It was then pointed out that the Council had gone into session at 10 a.m., and that it was 5 p.m. and many of the members had to travel long distances to their homes. While the agenda had not been completed, the Council adopted a motion to adjourn.

Senior Day Set for May 16

The 1960 Senior Day Program, honoring this year's graduates of the University of Louisville School of Medicine, will be held on May 16 at the Brown Hotel in Louisville, announces N. L. Bosworth, M.D., Lexington, chairman of the KSMA Committee on Public Information and Service. This annual affair is sponsored by the KSMA in cooperation with the Jefferson County Medical Society and the U. of L. School of Medicine.

The program is designed to give the senior medical student a glimpse into some of the facets of actual practice not included in his course of study. More details of the day's activities will be given in a later Journal.

West Va. AOO to Meet Apr. 10-12

The West Virginia Academy of Ophthalmology and Otolaryngology has announced April 10-12 as the date for its annual meeting at the Greenbrier Hotel, White Sulphur Springs. Guest speakers will include Harold G. Scheie, M.D., Professor of Ophthalmology, University of Pennsylvania School of Medicine; Charles E. Iliff, M.D., Associate Professor of Ophthalmology, John Hopkins University School of Medicine, and Oscar T. Becker, M.D., Clinical Associate Professor of Otolaryngology, University of Illinois.

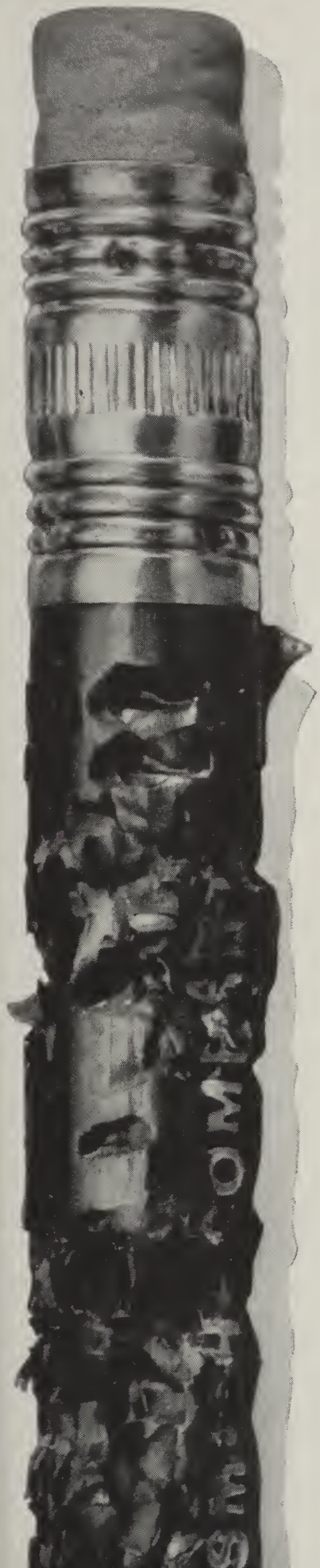
Additional information may be obtained by contacting the secretary, Albert C. Esposito, First Huntington National Bank Building, Huntington 1, W. Va.

Woman Heads Central State Staff

Dr. Nina Kateryniuk, Ukrainian-born psychiatrist, is the new chief of staff at Central State Hospital, directing the work of 12 residents, psychiatrists and physicians. Doctor Kateryniuk and her husband, Emilian, a chemist, were among more than 50 professional people who came to Kentucky as displaced persons about 10 years ago. She completed a three-year residency in psychiatry in December, after four years of internship and residency at Jewish, St. Joseph and General Hospitals, Louisville, and Central State.

U. L. Dental Dean Elected

Dr. Raymond Myers, dean of the University of Louisville Dental School, was elected president of the Southern Conference of Dental Deans at a meeting in Edgewater Park., Miss., on January 12. The conference is made up of deans of nine Southern dental schools. Dr. Myers has been on the Louisville Dental School's faculty since 1926 and the dean since 1945.



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Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. *80*:481 (Oct.) 1958. 2. Ferrand, P. T.: Minnesota Med. *41*:853 (Dec.) 1958. 3. Mathews, F. P.: Am. J. Psychiat. *114*:1034 (May) 1958.

SEARLE

News Items

James Emmet Alvey, Jr., M.D., a lieutenant in the U. S. Navy, has started part-time practice in association with D. G. Diebold, M.D., Louisville, while stationed with the Armed Forces Examining Station. Born in Louisville in 1931, Doctor Alvey was graduated from the University of Louisville School of Medicine in 1956 and served his internship at SS. Mary and Elizabeth Hospital, Louisville.

Richard A. Bahn, M.D., has joined the staff of surgeons at Harlan Memorial Hospital, Harlan. Born in Buffalo, N. Y., Doctor Bahn received his medical degree from the University of Buffalo in 1952. He served a one-year internship and a six-year residency in surgery at the E. J. Meyer Memorial Hospital in Buffalo.

Leslie W. Blakey, M.D., has joined the staff of the Lexington Clinic, Lexington, as a neurologist. He previously practiced in Hopkinsville in 1949 and in Cadiz, 1950-1955. Born in Hardyville, Doctor Blakey received his M.D. degree from the University of Louisville School of Medicine in 1947. He served his intership at Indianapolis General Hospital and took residency training at the Mayo Foundation for Medical Education and Research, Rochester, Minn., from 1956-1959. During 1956, he was a fellow in Internal Medicine, transferring to the field of neurology in January, 1957, and completing three years of formal training toward certification by the American Board of Neurology and Psychiatry.

David D. Drye, M.D., has reopened his office in Bradfordsville after serving as physician at a General Motors plant in Detroit for a short time. A 1953 graduate of the University of Louisville School of Medicine, Doctor Drye interned at General Hospital, Montreal, Canada, and started practice in his native Bradfordsville in 1954. He left to accept the Detroit post last October 1.

James A. Harris, M.D., has opened an office in the Citizens Bank Building, Paducah, specializing in urology. He was formerly head of the section of urology at the Lexington Clinic. Doctor Harris was born in Grandfield, Okla. After receiving his medical degree from Duke Unversity in 1950 he interned at Duke and took a three-year residency at the University of Virginia. A lieutenant colonel in the U. S. Marine Corps Reserve, Doctor Harris saw active duty from 1941-46.

Alberto Rigau, M.D., has resigned as associate chief of surgery at Harlan Memorial Hospital, Harlan, to accept the post of assistant professor of plastic and reconstructive surgery at Baylor University College of Medicine, Houston. Doctor Rigau, a native of Puerto Rico, holds D.D.S. and M.D. degrees from Marquette University. He received his surgical training at Johns Hopkins Hospital, Baltimore; Columbia-Presbyterian Medical Center, New York, and Guys Hospital, London University, England. He was a captain in the Army Medical Corps in Europe.

Dorothy Holtgrave, M.D., general practitioner of Louisville, is the new director of communicable-disease control of the Louisville-Jefferson County Health Department. She took office January 1, succeeding Geraldine Paxton, M.D., who resigned to take postgraduate medical training. Doctor Holtgrave, a 1957 graduate of the University of Louisville School of Medicine, will continue her private practice.

David Thurman Lewis, M.D., has started the practice of medicine in Elizabethtown, after serving as staff physician at Madison State Mental Hospital for six months. He took over the practice of Presley F. Martin, M.D., who will take postgraduate work in psychiatry. Born in Rineyville, Doctor Lewis was graduated from the University of Louisville School of Medicine in 1958 and interned at Philadelphia General Hospital. Before entering medical school, he served two years in the U. S. Air Force, attaining the rank of first lieutenant.

Presley F. Martin, M.D., has turned over his office in Elizabethtown to David T. Lewis, M.D., to accept a three-year scholarship from the National Institute of Medical Health to the University of Louisville School of Medicine. He will take postgraduate training in psychiatry. A native of Booneville, Ind., Doctor Martin received his M.D. degree from the U. of L. School of Medicine in 1951 and started to practice in Elizabethtown the following year. He was in the U.S. Air Force from 1953 to 1955.

William P. Peak, M.D., Louisville, has been elected president of the Kentucky Chapter, Arthritis and Rheumatism Foundation.

Kingsley M. Stevens, M.D., has joined the staff of the College of Medicine, University of Kentucky, as assistant professor of medicine. His specialty is immunology. Doctor Stevens, a native of Lynchburg, Va., received his medical degree from Harvard in 1947. He interned at North Carolina Baptist Hospital, served residencies in medicine at that hospital and at St. Joseph Hospital, Lexington, and did research in immunology and biochemistry at Bowman-Gray, the University of Chicago, Fort Sam Houston, Melbourne, Walter Reed and Merck Institute. He served two years in the U. S. Army as a captain in the Medical Corps.

Hubert F. Sturges, M.D., has joined John H. Leland, M.D., in the general practice of medicine in Crestwood and Prospect. Born in the Belgian Congo in 1927, Doctor Sturges was educated in the United States and returned to Africa in 1953 to serve as a medical missionary in Ethiopia until 1957. His previous practice also includes six months in Alamosa, Colo., in 1959. Doctor Sturges was graduated from the College of Medical Evangelists in 1952, after which he interned at Porter Sanitarium and Hospital, Denver. He served a 15-month residency in pathology at Loma Linda Sanitarium and Hospital in 1958-59.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1960 Annual Meeting — Kentucky State Medical Association

Columbia Auditorium — **Louisville, Kentucky** — **September 20, 21, 22**

Fill Out and Mail to:

J. THOMAS GIANNINI, M.D., Chairman

Committee on Scientific Exhibits

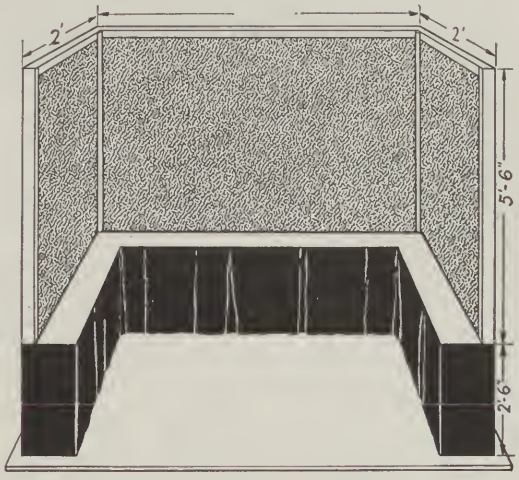
129 Medical Arts Building

1169 Eastern Parkway

Louisville 17, Kentucky

Applications for space should be received before July 1, 1960

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

Student AMA

The opportunity to pursue a summer of study abroad is an educational advantage which rarely comes to medical students. Recently, I was fortunate enough to obtain such an opportunity.

I spent the summer months of 1959 at Guy's Hospital, London, in the capacity of a student of clinical medicine. Guy's is a hospital founded in the early Eighteenth Century. Although its buildings are black with age and use, with all of its outmoded architecture and discolored exterior it is a hospital abounding in that intellectual stimulation which makes sheer pleasure of that most dificult of all processes—learning. It is a hospital built by tradition. One can almost hear the students' footsteps as they followed Thomas Addison and Richard Bright from bed to bed over a hundred years ago.

The student learns at the bedside; and what more stimulating means is there of imparting knowledge of the patient's disease than the use of the patient himself? If there is a single solid basis for the student's clinical acumen, it may be formulated in but two words: physical diagnosis. It is taught continuously throughout his clinical years. It is constantly demonstrated by his professors, and it always takes an important place in the instruction given to him by the latter's registrars (residents).

Neurology receives greater emphasis there than in most American schools. Each student starting his clinical training is well-acquainted with the neurological examination and makes good use of it in his "work-ups." Most of Guy's internists are loth indeed to cast off a patient merely because his disease is one of grey and white matter, despite the fact that there are several wards occupied entirely by neurology patients and staffed by neurologists.

There are, of course, many aspects justifiably open to criticism. One of these is the striking tendency, at least by our standards, to over-hospitalize the patient. Since the inception of the National Health Act, which has served to relieve the patient of direct financial burden for his hospitalization, there has been a natural trend to hospitalize the patient for a greater length of time. Undoubtedly this has been due to more leisurely diagnostic evaluation and regimens of treatment, and, while it may make for better teaching, there can be little doubt that it delays the patient's return to his home, family and employment, serves only to augment an already lengthy waiting-list of patients seeking admission, and, what is perhaps most important, it increases the patient's dependence upon governmental support.

The advantages that come with a summer of study abroad are innumerable: gathering new perspectives, assimilating new ideas expressed in entirely new ways, discussing old ideas with new acquaintances on common ground—all of these contributing to the whole in such a way that the visiting student can only look back upon his enlightening experience with the feeling of having gained something very special and very rare.

Richard H. Gold
Senior Class Representative
SAMA Executive Council
U. of L. School of Medicine

Surgery Unit Named For Dr. Ryan

The new $1,500,000 J. A. Ryan Surgical and X-ray Pavilion at Covington's St. Elizabeth Hospital is named in honor of the first doctor to do major surgery at the hospital, James Andrew Ryan, M.D. Doctor Ryan was the chief surgeon there for 23 years.

The new department houses 12 operating rooms, each equipped for specialized work. One is for eye surgery, two have ceiling-mounted, crane-type x-ray units, other rooms have special equipment for studies of the heart and blood vessels, the brain and spinal cord, and the kidneys and urinary tract.

Five New Members Listed

Five new names have been added to the KSMA membership roster. The new members are:

Robert H. Shipp, M.D., Shelbyville
Hubert F. Sturges, M.D., Crestwood
Horace W. Addams, M.D., St. Matthews
Ferrell C. Lowrey, Jr., M.D., Louisville
Leslie Van Nostrand, M.D., Louisville

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A non-profit mental health center offering modern diagnostic and treatment procedures.
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Wm. N. Lipscomb, M.D.
Orcena F. Knepper, M.D.

Edward L. Houchin, *Administrator*

Phone: 2-2050

County Society Reports

McCracken County

A discussion of the Forand bill was one of the high lights of the December meeting of the McCracken County Medical Society, at which First District Congressman Frank A. Stubblefield was a guest. He was introduced by John Quertermus, M.D., Murray. It was the general concensus that the society's views on the subject should be relayed to the Ways and Means Committee of the House.

The program committee, one of several making reports, announced that Dr. A. G. Kammer of the University of Pittsburgh would speak on "Industrial Medicine," at the January meeting. The legislative committee recommended support of the KSMA-backed bill giving the local county medical societies more control over their respective health departments. The health clinic committee reported that a Paducah city ordinance requires food handlers to be examined by physicians licensed in Kentucky, and a motion was passed to disapprove an application from an Illinois physician to do this type of examination. The mental health committee reported the Mental Health Clinic would be located in the Katterjohn Building after January 1, under the direction of Dr. Paul Davis, a psychiatrist.

Officers elected for 1960 were: William W. Myre, M.D., president; Joe B. Spaulding, M.D., vice-president, and Glenn R. Noss, M.D., secretary. Walker Turner, M.D., was chosen delegate to KSMA and Robert M. Woolridge, M.D., was named alternate delegate.

A motion was passed that the society go on record as supporting the proposed School of Licensed Practical Nursing to be established at Western Baptist Hospital in the near future.

At its **November** meeting, the McCracken Society voted to allocate $295 to make up a shortage in the amount needed to promote the fluoridation of water. The request of James A. Harris, M.D., for transfer from the Fayette County Society to the McCracken Society was approved unanimously.

Harlan County Society Elects

Oscar Cawood, M.D., is the new president of the Harlan County Medical Society, heading the list of 1960 officers that includes Doane Fischer, M.D., vice-president, and William H. Anderson, M.D., secretary-treasurer.

Also elected at the group's December meeting were: E. M. Howard, M.D., and David McLean Greeley, M.D., delegates to the KSMA, and Philip Begley, M.D., and Walter Stepchuck, M.D., alternate delegates. Doctor Begley, Paul O. Wells, M.D., and H. C. Burkhart, M.D., were reelected to the board of directors, and Doctor Burkhart was renamed to the board of censors which also includes Julia Arrowood, M.D., and James D. Foley, M.D.

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Psychotherapy and occupational therapy

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Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director

Committee Reports

Committee on Public Information and Service

N. L. Bosworth, M. D., Chairman

Lexington **December 10**

This committee recommended to the KSMA Council:

That the organization known as the American Medical Assistants Association be officially endorsed by the KSMA:

That a repeat of the "Doctor's Secretary Course" be held again at a later date;

That guides for county society presidents and application forms for the use of county society secretaries be distributed by the KSMA Headquarters Office;

That consideration be given to getting out a news release on free time, etc., donated by the physicians, and that the Practical Nurse Training Program be sanctioned by the KSMA along with a request that more use of matching Federal funds be made;

That steps be taken to clarify the status of the medical rider on Blue Shield post-operative coverage and that a joint KSMA-Blue Shield-Blue Cross meeting be held for all interns and residents before they go into actual practice in 1960.

Plans were also discussed for the 1960 Senior Day program, exhibits at the State Fair and KEA, the welcoming luncheon for new physicians, and material for Newscaps.

Committee on Medical Education and Economics

Gaithel Simpson, M. D., Chairman

Louisville **November 20**

This committee initiated plans for contacting two of the larger Louisville banks relative to a proposed plan that would take advantage of the tax-saving features under the proposed Jenkins-Keough legislation. This step was taken at the request of the 1959 House of Delegates.

Noting that only a few replies had been received from the county medical societies concerning their wishes about conducting a relative value study in Kentucky, it was suggested that the counties be contacted again and asked to submit their decisions in the matter to the KSMA Headquarters Office.

After the meeting, members of the committee were guests of the Jefferson County Medical Society at a dinner honoring William J. Reals, M.D., Wichita, Kan. Doctor Reals appeared in Louisville to address the Jefferson County Society on aspects of a relative value study.

"Clinical Pharmacology and Therapeutics" made its bow in January as the official publication of the American Therapeutic Society. The aim of this new addition to current medical literature, according to its publishers, is to provide what the profession has long needed—a single source of comprehensive and authoritative coverage; a journal devoted exclusively to applied pharmacology. For subscriptions, write to the C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Mo. The subscription rate is $12.50.

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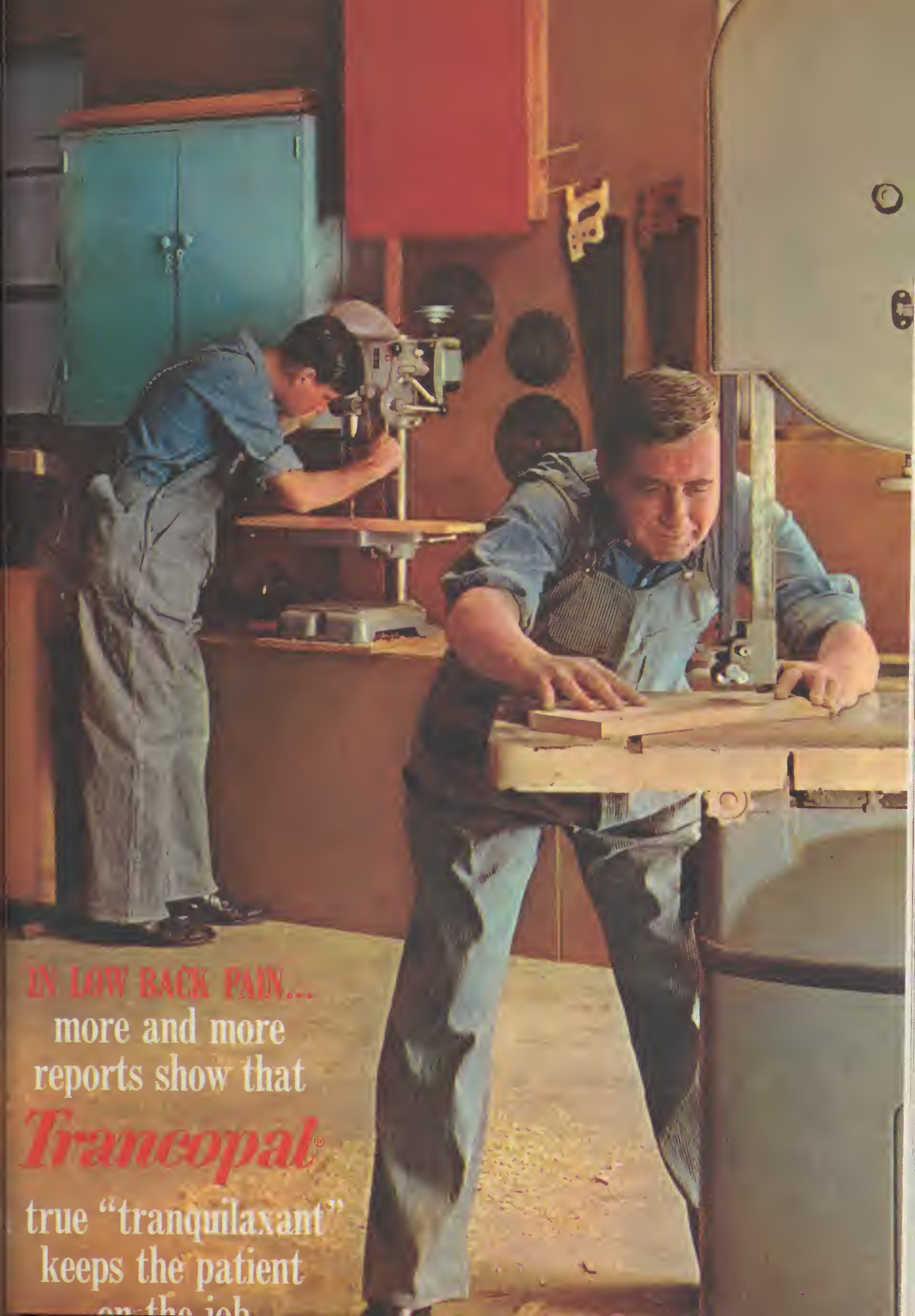
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Impressive numbers of patients with low back pain and other musculospastic conditions treated with Trancopal have been freed of symptoms and enabled to return to their usual activities, according to newly published clinical reports. In a recent study by Lichtman,[1] Trancopal brought excellent to satisfactory muscle relaxation to 817 of 879 patients. The patients in this group suffered from skeletal muscle spasm associated with low back pain (361 cases), stiff neck (128 cases), bursitis (177 cases), and other skeletal muscle disorders (213 cases). Side effects were rare (2 per cent of patients), and it was not necessary to discontinue medication in any of the patients. Lichtman comments: "Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[2]

When you prescribe Trancopal for musculoskeletal disorders, you can confidently expect that your patients will be relieved of the pain and stiffness. You can be sure of their speedy return to everyday work and recreation.

ullin and Epifano call Trancopal "...a very effective skeletal muscle spasmolytic."[3] hey found that Trancopal brought good to excellent relief to all of 39 patients with eletal muscle spasm related to trauma, bursitis, rheumatoid arthritis, osteoarthritis, and tervertebral disc syndrome. (No side effects were noted except that one patient had slight yness of the mouth.)

he pattern is similar in every new series reported: Ganz,[4] DeNyse,[5] Shanaphy[6] and Stough.[7]

Trancopal is a true "tranquilaxant"

rancopal "...combines the properties of tranquilization and skeletal muscle relaxation ith no concomitant change in normal consciousness."[6]

Relieves dysmenorrhea



Trancopal not only is valuable in treating patients with low back pain and other musculoskeletal disorders, but is also very effective in bringing relief from menstrual cramps and discomfort. Shanaphy suggests that Trancopal may help the patient by its combination of muscle relaxant and tranquilizing actions, and he finds that "...the continued use of chlormezanone [Trancopal] as a therapeutic agent in dysmenorrhea is advisable."[6] Trancopal was effective in 82 per cent of his series of 50 patients. In another study, which dealt with 52 adolescent girls and 23 women, Stough[7] reported that Trancopal gave complete or moderate relief in 86.4 per cent.

Alleviates tension

nd, of course, Trancopal is also very useful in the treatment of patients in anxiety nd tension states. As Ganz says, "...a most valuable drug for relieving tension, pprehension and various psychogenic states...allows the patient to use his energies in more productive manner in overcoming his basic problems."[4]

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that relieves skeletal muscle spasm and relaxes psychogenic tension without troublesome side effects, and keeps the patient on the job.

Indicated for...

Musculoskeletal disorders		Psychogenic disorders
Low back pain (lumbago)	Fibrositis	Anxiety and tension states
Neck pain (torticollis)	Ankle sprain, tennis elbow	Dysmenorrhea
Bursitis	Myositis	Premenstrual tension
Rheumatoid arthritis	Postoperative muscle spasm	Asthma
Osteoarthritis		Angina pectoris
Disc syndrome		Alcoholism

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Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.



Professional models used for photographs

References: 1. Lichtman, A. L.: Scientific Exhibit, meeting of the International College of Surgeons, Miami Beach, Fla., Jan. 4-7, 1959. 2. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 3. Mullin, W. G., and Epifano, Leonard: *Am. Pract & Digest Treat.* 10:1743, Oct., 1959. 4. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 5. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 6. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 7. Stough, A. R.: *J. Oklahoma M. A.* 52:575, Sept., 1959.

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In Memoriam

W. B. WALLIN, M.D.
Brooksville
1870 - 1959

The 1954 winner of the KSMA Outstanding General Practitioner Award, William B. Wallin, M.D., died on December 15 at his home in Brooksville. He was 89.

Doctor Wallin, who had practiced medicine almost 60 years, was a member of a medical family whose service to Bracken County spanned more than a century. His father, Dr. David Jackson Wallin, was one of the county's physicians during the mid-1800's and his brother, Dr. Corlis Wallin, practiced in Brooksville until his death in 1935. Doctor Wallin was graduated from the Medical Department of the University of Louisville in 1893.

E. L. BRANAMAN, M.D.
Taylorsville
1872 - 1960

E. L. Branaman, M.D., who retired five years ago after a 60-year practice in Shelby and Spencer counties, died on January 3 in Guerrant Clinic, Winchester. He was 88.

Doctor Branaman was graduated from the University of Louisville Medical School in 1894. He was a member of the Spencer County Board of Health.

REMUS G. CARY, M.D.
Sorgho
1871 - 1960

Remus Griffith Cary, M.D., Daviess county physician for more than 50 years, died on December 27 at his home in Sorgho. Eighty-eight years old, he had retired from active practice.

Doctor Cary was graduated from the Kentucky School of Medicine in 1897 and returned to his native Daviess county to begin the practice of medicine.

E. O. WITHERSPOON, M.D.
Louisville
1879 - 1960

Ezra O. Witherspoon, M.D., retired physician and surgeon who practiced in Louisville for half a century, died on January 3 at the age of 81. He was an emeritus member of KSMA.

A native of Lawrenceburg, Doctor Witherspoon was graduated in 1901 from the old Hospital College of Medicine, Louisville, where he later taught chemistry and surgery. He was assistant health officer of Louisville from 1909-1917. Before retiring, he was head physician in Kentucky for the Modern Woodmen of America for about 30 years.





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*Innerfield, I.: Clinical report cited with permission.

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SYNOPSIS OF OPHTHALMOLOGY: by William H. Havener, M. D.; published by the C. V. Mosby Company, St. Louis, 1959; 288 pages; price, $6.75.

It is always refreshing and welcome to encounter the terse, lucid style so necessary in a synopsis of this type.

This almost pocket-size work will be especially valuable to the non-opthalmologist as an introduction and review to the sometimes forgotten and neglected, but all important, details of ocular care. Within the limits a survey necessarily imposes on itself, the practical and useful facts are given us in rapid fire sequence. These are pleasantly punctuated by a uniformly good series of black and white photographs.

A certain few subjects and a few details are given unexplained and unexpected emphasis. While the work does not pretend to be an opthalmologic reference work or text book, this segmental elaboration makes it more than a summary as well as more readable. The two chapters on the diagnosis and management of eye injuries and the red eye will be found particularly rewarding to the general practitioner whose prompt initial diagnosis and care many times determine the final visual outcome. The mechanics of proper examination of the injured eye and the differential diagnosis of the red eye are concisely set forth.

This synopsis of ophthalmology more than adequately carries the author's message that "blindness is preventable."

Edward C. Shrader, M.D.

THE SURGEON AND THE CHILD: by Willis J. Potts, M. D., Surgeon-in-Chief Children's Memorial Hospital; Professor of Pediatric Surgery, Northwestern University Medical School, Chicago; published by W. B. Saunders Company, Philadelphia, 1959; price, $7.50

This 250-page book on surgical conditions of children covers all the major problems of children's surgery. The first 16 pages of the book are particularly impressive since they seem to contain the pleas of a mother, a pediatrician, and a pediatric psychiatrist. The fact that these pages have been written by a busy surgeon, who has gained the major portion of his fame through his work in cardiovascular surgery, adds additional weight to the writing.

This is in no sense a textbook on pediatric surgery. The illustrations are sparse, the statistics are almost non-existent, and no young house officer is going to learn to perform intricate surgical procedures through the study of this book. However, there is probably no better book available as an introduction to the surgery of infancy and childhood, and it is up-to-date so far as the current trends in surgical care are concerned.

Doctor Potts has made no attempt to solve the problems beyond relating the experiences of the staff at the Children's Memorial Hospital in Chicago, and he ts quite emphatic about listing their opinions as "clinical impressions" rather than "scientific conclusions."

It is difficult to find anything with which to take issue in a book that is so honestly written, and which is obviously the result of years of serious thought and tender pediatric surgical care. There are individual points in the book with which anyone might differ; however, the results speak for themselves, and the forthrightness with which the conclusions are presented leaves this an ideal introduction or quick refresher for the medical student, house officer, family doctor, pediatrician, general surgeon, or pediatric surgeon. Each and everyone will undoubtedly profit personally as a result of reading this little monograph, and thereby enhance his value to his own patients.

This book belongs in the library of every physician and every hospital.

Hugh B. Lynn, M.D.

INSULIN TREATMENT IN PSYCHIATRY: edited by Max Rinkel, M.D., and Harold E. Himwich, M.D.; published by the Philosophical Library, New York, 1959; 380 pages, price, $5.00.

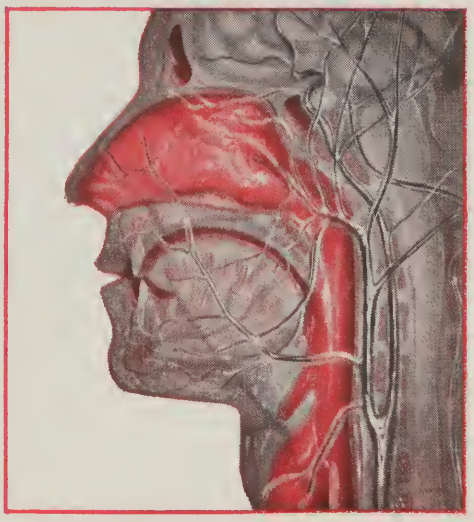
This book, a monument to Sakel, is a report on an international conference held at the New York Academy of Medicine under the joint commission of the two editors, assessing the value of insulin treatment of psychoses and portraying a global view of such treatment, to learn of its failures and successes and to compare results with those of other therapies. Some very definite evidence that insulin therapy is not as efficacious or as curative as might be indicated is brought out.

Men of distinction in scientific and clinical investigation present papers. Han Hoff, M.D., professor at the University of Vienna and proponent of Sakel's treatment, gives historical account of the development of the concept of schizophrenia; his approach is obviously empirical. Insulin may compare better when long term results with tranquilizers are evaluated.

Ivan F. Bennett, M.D., discussed hormonal and blood changes occurring during insulin hypoglycemic treatment; inconsistent results were explained by the

(Continued on Page 232)

reaches all nasal and paranasal membranes *systemically*[1]



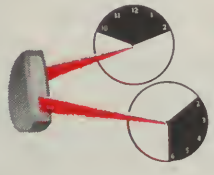
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Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides: ¼ the formulation of the Triaminic Tablet.

Dosage (to be administered every 3 or 4 hours): *Adults* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

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IN THE BOOKS

(Continued from Page 230)

lack of proper controls and baselines. Williamina Himwich, Ph.D., concluded that in hypoglycemia the change in acetylcholine and serotonin decreases due to lack of energy required to build up in the brain. Harold Himwich, M.D., said successful treatments of schizophrenia affect the rhinencephalic structures; the rhinencephalon is probably the anatomic substrate of the emotions.

Max Rinkel, M.D., concludes that most of the organic treatments have been on a trial-and-error basis. Weight gain has been observed by all authors in most patients who have improved with insulin therapy. Fatal cases occur in the use of Reserpine in hypoglycemic treatment. Paul Hoch, M.D., emphasized the need for research and stressed the differences in treatment of acute and sub-acute schizophrenics versus chronic schizophrenics.

Insulin has returned patients to society, has tremendously altered our index of treatment and changed our outlook for the schizophrenic. It has increased our efforts to more research, more treatment, and more vigorous assault on the psychiatric problems. We need to investigate our psychiatric theories on a bio-chemical, physiological, psychological basis and correlate them before we can come to any hard and fast conclusions.

Louis M. Foltz, M.D.

Dr. Lull Serving Illinois Society

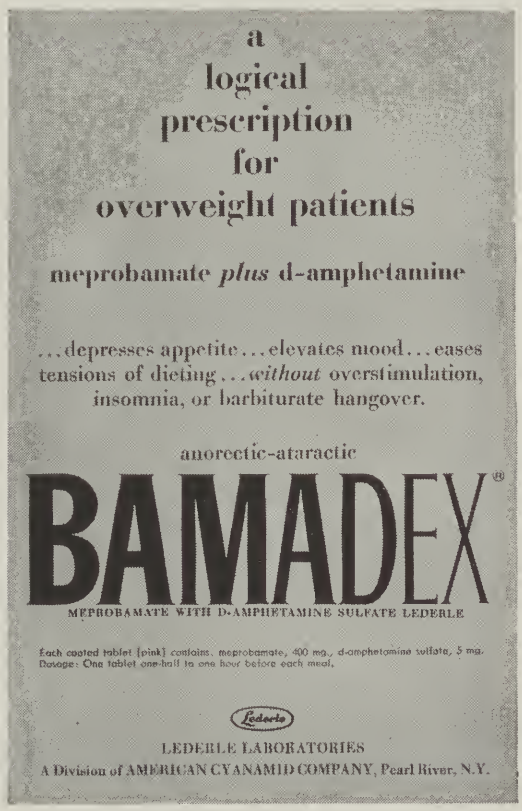
George F. Lull, M.D., secretary and general manager of the American Medical Association until his retirement two years ago, is now serving as secretary-treasurer of the Illinois State Medical Society, dividing his time between the Chicago and Monmouth offices. His interim appointment followed the death in October of Harold M. Camp, M.D., who had been secretary-treasurer of the society since 1924.

The Illinois Society, according to its January News-Letter, will revise its bylaws at its annual meeting in May to change its organizational setup.

Drug Firms Exonerated

The Federal Government's antitrust case against five large drug manufacturers for allegedly fixing Salk polio vaccine prices from 1955 to 1957 was thrown out of the U. S. District Court in Trenton, N. J., in November, 1959. Federal Judge Philip Forman dismissed charges of criminal conspiracy against the companies without waiting for the defense arguments.

Judge Forman, in a lengthy opinion, said that when the basic elements of the case were considered, "there remains only the allegation that the defendants consciously charged uniform prices to public authorities . . . and refused to reduce them, although repeatedly asked to do so. That their actions were not independent and were contrived, cannot be but a matter of suspicion and conjecture."





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Complete references and a Professional Information Booklet giving detailed information on NIAMID are available on request from the Medical Department, Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York

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Diagnostic Quandaries

Colitis? Gall Bladder Disease?
Chronic Appendicitis?
Rheumatoid Arthritis? Regional Enteritis?

A DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.[1]

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica*. In 15 of these subjects, nine stool specimens were required to establish the diagnosis.[2]

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.[3]

Now treatment with Glarubin provides a means of differential diagnosis in suspected cases of amebiasis. Glarubin, a crystalline glycoside obtained from the fruit of *Simarouba glauca*, is a safe, effective amebicide. It contains no arsenic, bismuth, or iodine. Its virtual freedom from toxicity makes it practical to treat suspected cases without undertaking difficult, and frequently undependable, stool analyses. Marked improvement following administration of Glarubin indicates pathologically significant amebic infection.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis.

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1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. *6*:1821 (Dec., 1955).

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. *9*:897 (June, 1958).

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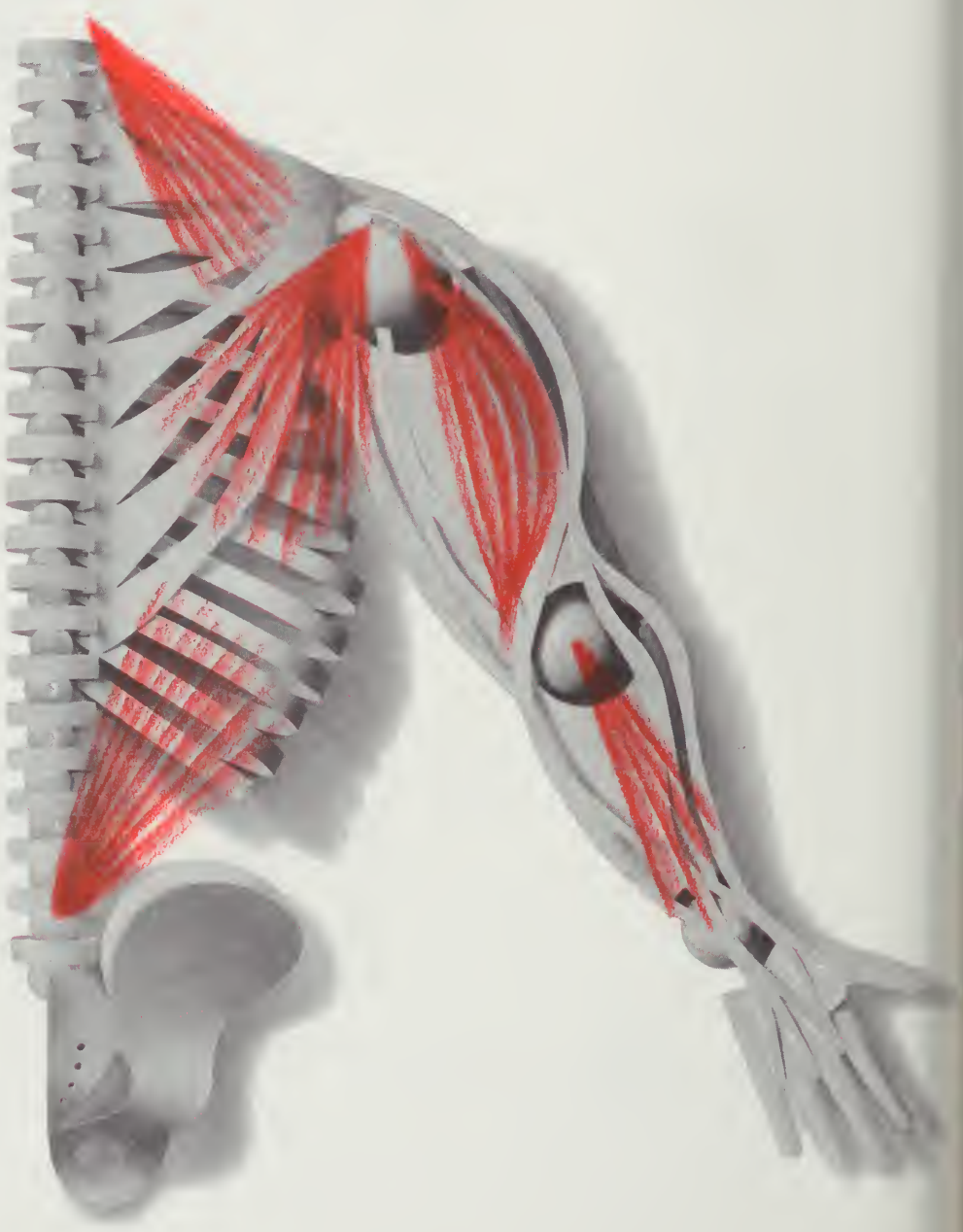
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Kuge, T.: Submitted for publication.

"In 86 percent of the patients there were excellent or good results. . . . Relief of pain was noted by the patients' statements, by the diminished need for analgesic drugs, and by improved sleep." (154 patients.)
Wein, A. B.: The Use of Carisoprodol in Orthopedic Surgery and Rehabilitation. Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol. Wayne State University Press, Detroit, 1959, p. 156.

In a double-blind study, SOMA was reported to be "clinically effective to a highly significant degree." (92 patients.)
Cooper, C. D., and Epstein, J. H.: The Clinical Evaluation of Carisoprodol by a double-blind technique. Ibid. p. 97.

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BIBLIOGRAPHY: 1. Berger, F.M., Kletzkin, M., Ludwig, B.J., Margolin, S. and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 2. Leake, Chauncey D.: Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959, p. 8. 3. Kestler, Otto: Ibid. p. 143. 4. Proctor, Richard C.: Ibid. p. 122. 5. Berger, Frank M., Ibid. p. 25. 6. Goodgold, Joseph, Hohmann, Thomas and Tajima, Toshihiro: Ibid. p. 66. 7. Gammon, George D. and Tucker, Samuel: Ibid. p. 70. 8. Baird, Henry W. and Menta, Dominic A.: Ibid. p. 85. 9. Cooper, C. David and Epstein, Jerome H.: Ibid. p. 97. 10. Korst, Donald R., Gerard, R. W., Miller, James G., Small, Iver F., Graham, I. J. and Winkelman, Eugene I : Ibid. p. 104. 11. Friedman, Arnold P.: Ibid. p. 115. 12. Trimpi, Howard D.: Ibid. p. 150. 13. Wein, Arthur B.: Ibid. p. 156. 14. Olds, James and Travis, R. P.: Ibid. p. 39. 15. Hess, Eckhard H., Polt, James M. and Goodwin, Elizabeth: Ibid. p. 51. 16. Phelps, Winthrop M.: Ibid. p. 131. 17. Spears, Catherine E.: Ibid. p. 138. 18. Hyde, L. P. and Hough, Charles E.: Ibid. p. 166. 19. Spears, Catherine E. and Phelps, Winthrop M.: Arch Pediat., *76*:287 (July) 1959. 20. Phelps, Winthrop M.: Arch. Pediat., *76*:243 (June) 1959. 21. Friedman, Arnold P.: Paper presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 22. Frankel, Kalman: Ibid. 23. Fransway, Robert L.: Ibid. 24. Kuge, T.: Unpublished reports.

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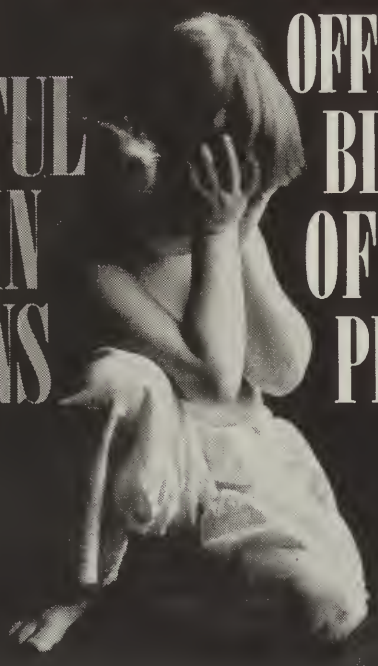
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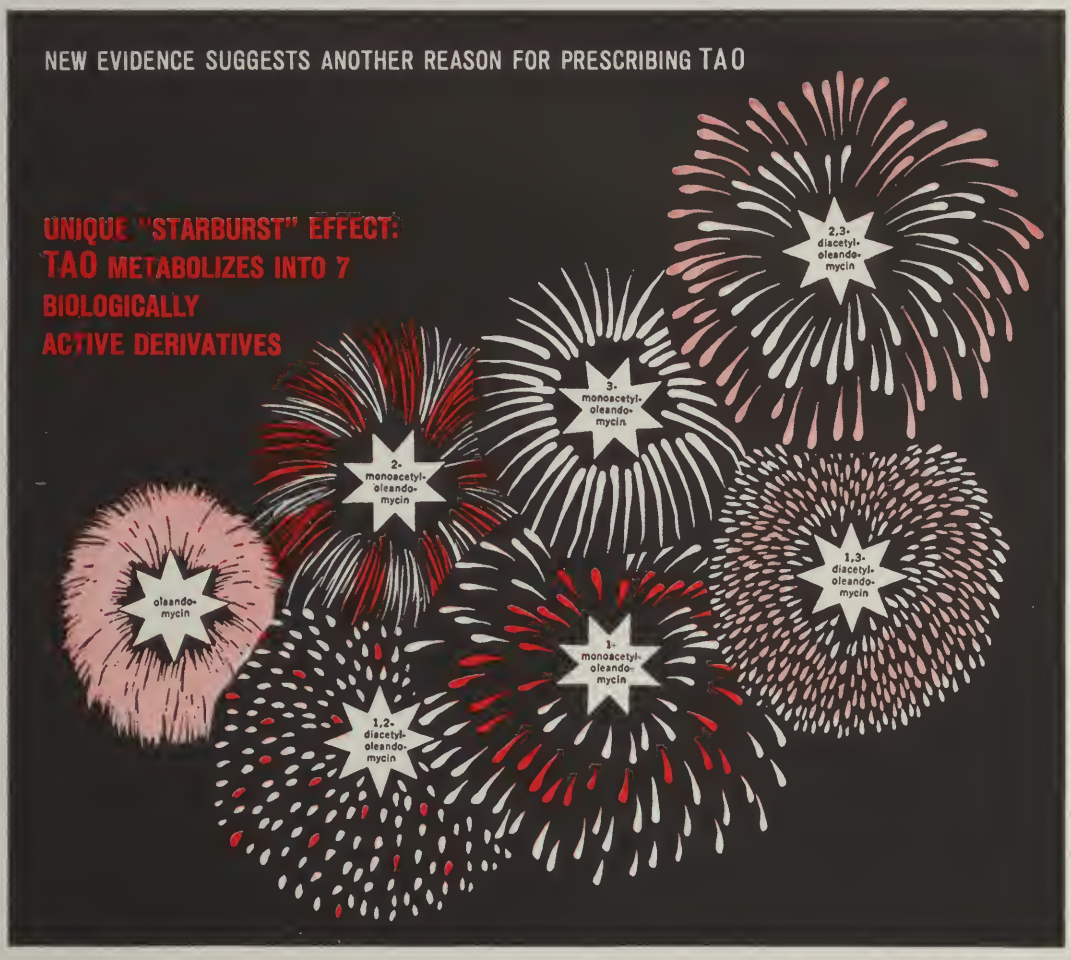
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CASE #49: This patient was a 28-year-old married white gv. 2 para 1 who saw her private physician in her second month of pregnancy. Her LMP was 12-7-57 and by menses she was due September 14, 1958.

Her past medical, surgical and obstetrical history was sketchy. The initial section was done because of a contracted pelvis, although the type was not noted. She had three episodes of bronchitis during this current pregnancy and one episode of dark vaginal bleeding at 2 1/2 months. This stopped and did not recur.

She was hospitalized at 38 weeks for an elective repeat section. She had no evidence of infection on admission to the hospital. Her Hgb was 13 grams. No mention was made of using x-ray to demonstrate the distal femoral epyphysis of the infant as a help in judging the size of the infant. There was no mention of the condition of the cervix.

A classical section was done 8-25-58. The premedication was Methodane 5 mg., Phenergan 25 mg., and atropine 1/150 gr. The type of anesthesia wasn't mentioned. A living 6 lb., 11 oz. girl was delivered. The blood loss at surgery was put at less than 300 cc. She was kept on i.v. fluids until good bowel sounds were heard. It wasn't stated for how long this was necessary, nor was there any mention of temperature or antibiotic administration.

She was given Ilopan and prostigmine from the time of surgery and on the third postoperative day. She refused to be ambulated and complained of pain when she breathed deeply. On the seventh day she was still distended and went into shock. On opening the patient, the colon was distended and had perforated at the junction of the ileum. She expired 24 hours later from peritonitis.

Comments

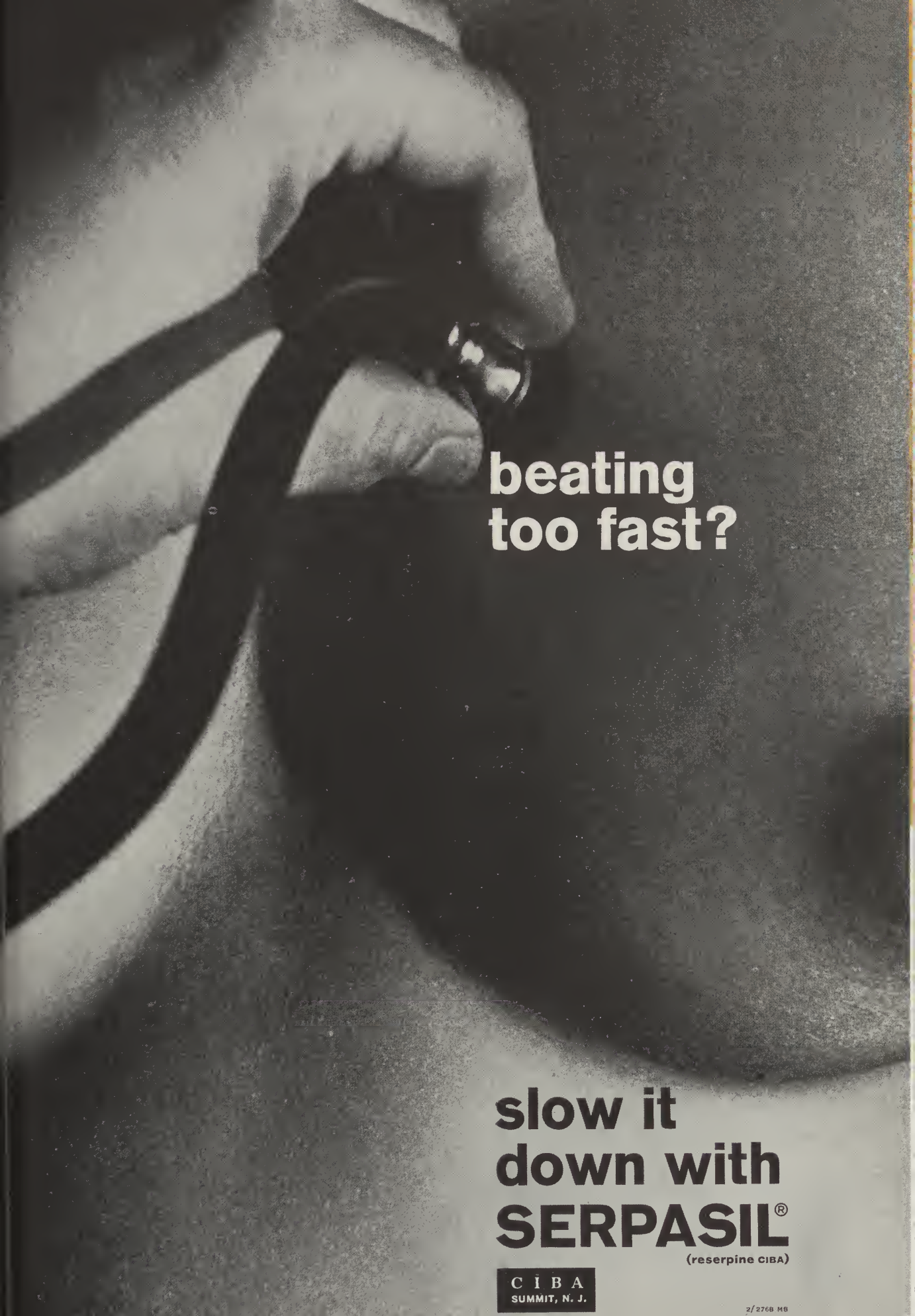
The Committee felt this was a direct obstetrical death that was possibly preventable by the physician. The chief problem the Committee has had to face is the failure to have a complete summary of the events that preceded the death. If the patient was hospitalized it would aid tremendously if the hospital records, including nurses' notes, could be made available.

Unexpected intestinal rupture associated with pregnancy is quite uncommon. In the August, 1959, issue of Obstetrics and Gynecology, Doctors Morton and Hibbard reported seven cases of intestinal rupture from the early puerperium up to 13 days postpartum. In these, the point of rupture was the cecum in four cases, the ileum twice and the transverse colon once. Three of the cases occurred at the site of ulcers or near the site of an appendectomy, while four were considered as diastatic. Only one of the seven survived.

They concluded from their study that more attention should be paid to possible bowel complication in the first three days. Diastatic rupture in the absence of associated disease of the bowel as described by Cannel and Tovec may be ruled out or corrected by placing the patient in the knee-chest position. The authors also recommend that considerable caution should be exercised in doing any elective appendectomy at the time of a cesarean section.

	Month of Pregnancy											
	1	2	3	4	5	6	7	8	9			
									1	2	3	4
Blood pressure			120/70	110/70	110/70	110/70	120/70	120/70	120/70			
Weight			123	131 ¼	134 ¾	136	140 ¼	142	144			
Urine			neg	neg	few WBC	neg	loaded WBC	neg	neg			

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March 9 and 10, 1960

6th Annual Symposium on Cardiovascular Diseases

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Wednesday, March 9

"Diuretics"

JOHN H. MOYER, M.D., Chairman, Department of Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania.

"Evaluation of Therapy in Primary Hypertension"

GEORGE A. PERERA, M.D., Associate Professor of Medicine, Columbia University College of Physicians and Surgeons, New York City.

"The Secret of Success in the Surgery of Acquired Valvular Disease"

ROBERT P. GLOVER, M.D., Assistant Professor of Clinical Surgery, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania.

Panel on *"Congestive Heart Failure"*

RALPH M. DENHAM, M.D., Moderator; HENRY T. BAHNSON, M.D.; ROBERT P. GLOVER, M.D.; JOHN H. MOYER, M.D.; PAUL M. ZOLL, M.D.

"Cardiac Resuscitation"

PAUL M. ZOLL, M.D., Associate Professor of Clinical Medicine, Harvard University Medical School, Cambridge, Massachusetts.

"Vascular Surgery"

HENRY T. BAHNSON, M.D., Associate Professor of Surgery, Johns Hopkins University, Baltimore, Maryland.

"The Use of Fibrinolysin in Vascular Disease"

ANTHONY P. FLETCHER, M.D., Assistant Professor of Medicine, Washington University School of Medicine, St. Louis, Missouri.

"The Highway Accident as a Common Cause of Trauma to the Heart and Great Vessels"

THOMAS W. MATTINGLY, M.D., Director of Medical Education, Washington Hospital Center, Washington, D. C.

Thursday, March 10

"The Postexercise Electrocardiogram in the Detection of Coronary Disease and Spurious Heart Disease"

THOMAS W. MATTINGLY, M.D., Director of Medical Education, Washington Hospital Center, Washington, D. C.

"Anticoagulant Therapy"

E. STERLING NICHOL, M.D., Clinical Associate Professor of Medicine, University of Miami, Miami, Florida.

"Neurological Complications of Hypertension"

CLARK H. MILLIKAN, M.D., Associate Professor of Neurology, Mayo Foundation, Rochester, Minnesota.

Panel on *"Cerebral Vascular Problems"*

EPHRAIM ROSEMAN, M.D., Moderator; C. H. MILLIKAN, M.D.; E. STERLING NICHOL, M.D.; HANS SELYE, M.D.; CHARLES E. WELLS, M.D.

"Stress and Cardiac Infarcts"

HANS SELYE, M.D., Professor and Director, and PIERRE JEAN, M.D., Institut de Medicene et de Chirurgie Experimentales, Universite de Montreal, Montreal, Canada.

"Cerebral Circulation"

CHARLES E. WELLS, M.D., Assistant Professor of Medicine, Cornell University Medical College, New York City.

"Pitfalls in the Diagnosis of Congestive Heart Failure"

R. BRUCE LOGUE, M.D., Professor of Medicine, Emory University Medical School, Atlanta, Georgia.

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1. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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SPECIAL ARTICLE

(Continued from Page 206)

and feasibility of establishing a home for aged and retired physicians;

Commended F. S. Crockett, M.D., retiring chairman of the Council on Rural Health, for his many years of devoted duty;

Urged active promotion and caseful study of the newly-developed "Guides for Medical Care and Nursing Homes and Related Facilities";

Registered a strong protest to the Veterans Administration, urging stricter screening of non-service-connected disability patients admitted to government hospitals;

Declared that the threat of nuclear warfare has imposed a tremendous responsibility on the medical profession, which must be prepared to assume a critically important role in such an event;

Suggested that the AMA make available to schools and libraries information and literature showing the advantages of private medical care in the American Free Enterprise System;

Approved the Speaker's proposal that the opening session of the House be moved from Tuesday morning to Monday morning, with the Reference Committees meeting on Tuesday and the House reconvening on Wednesday afternoon;

Called upon each individual physician to wage "a vigorous, dynamic and uncompromising fight" against the Forand type of legislation;

Urged state and local medical societies and individual physicians to implement the AMA program for recruitment of high grade medical students; and

Reaffirmed the "Suggested Guides to Relations between Medical Societies and Volunteer Health Agencies," which were adopted at the December, 1957, meeting in Philadelphia.

The Annual Meeting of the AMA will be held in Miami in June, 1960. Your team of delegates, alternate delegates, the executive secretary and interested physicians stand ready at all time to be of all possible assistance to members of the Kentucky State Medical Association.

ROBERT C. LONG, M.D.

Willkie, Former Drive Head, Dies

The death of H. Fred Willkie in December in a Wisconsin rest home recalled for KSMA his valuable contribution to the Rural Medical Scholarship Fund during the years he lived in Louisville.

Mr. Willkie was chairman of the General Funds Committee for the campaign conducted by the Scholarship Fund, from October 21, 1946, to April 10, 1947, to raise $100,000 to educate doctors for rural Kentucky through a revolving loan system. Almost $150,000 in contributions and pledges was received. Later, Mr. Willkie was made a member of the Fund's board of trustees to represent industry, at the suggestion of the board chairman, C. C. Howard, M.D., Glasgow.

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PUBLIC HEALTH PAGE

Infectious Hepatitis In Kentucky

Russell E. Teague, M. D.

Commissioner of Health,
Commonwealth of Kentucky

INFECTIOUS hepatitis is a contagious disease characterized by necrosis of individual liver cells. Although described in the writings of Hippocrates in the 5th Century B.C., the disease has only recently been classified as a specific disease entity. As yet the etiological agent has not been isolated, but most authorities agree that it is undoubtedly viral.

Infectious hepatitis is world-wide in distribution and occurs mainly where crowded and unsanitary conditions exist. Clinical cases are most prevalent in children between 5 and 14 and young adults between 20 and 39 years of age. Seasonal trends in incidence have been noted, with the greatest number of cases reported during the autumn and winter months.

Although racial resistance is not commonly recognized, it is of interest to note that over a seven-year period during which 4,543 cases were reported in Kentucky, only 1.4 per cent occurred in non-whites. (Slightly over 7 per cent of Kentucky's total population is non-white.)

During 1959, hepatitis ranked ninth in total number of cases of the communicable diseases reported in Kentucky. In recent years there have been several severe outbreaks of infectious hepatitis in the state. Epidemiological studies have been instituted in an attempt to identify the source of infection and halt its spread.

In August of 1954, a request from a western Kentucky county for epidemiological assistance during an infectious hepatitis epidemic was received by the State Health Department. A Public Health Service team was sent to the predominantly rural area which had a population of approximately 20,000 persons. Within two months 190 reported cases occurred in this county. An extensive epidemiological study was made, but no common source was ever found. The mode of spread appeared to be person-to-person contact, and no geographical or institutional foci of high incidence for the disease were noted. An unusual feature of this outbreak was a rather high attack rate among older age groups.

An alarming number of infectious hepatitis cases occurred in one of Kentucky's southwestern counties in 1956. This outbreak was confined to a small rural area. A team of epidemiologists was summoned, and after an extensive investigation the following hypothesis was formulated: "The epidemic was caused by fecal contamination of drinking water." This hypothesis appeared to be substantiated by the detection of a fluorescein dye in four private wells within 30 hours after it had been placed in several toilet bowls in the area.

During recent months an alarming number of infectious hepatitis cases were reported from one of Kentucky's eastern counties. A State Epidemiologist and a Public Health Service investigator were assigned to study the outbreak and make recommendations for controlling the epidemic. Cases occurred primarily among young children and were geographically restricted to a very rural portion of the county.

After extensive investigation it was concluded that the agent was spread by two means: food contaminated by a school cafeteria cook who was ill and remained on the job, and water from an old well which was being consumed by residents of a small settlement.

The most recent epidemic of interest occurred in a consolidated school in central Kentucky. Assistance of the State Epidemiologist was requested after there had been 21 cases of infectious hepatitis reported from this school. The number of cases soon reached a total of 50.

Investigation revealed that the effluent sewage from a sand filter drained directly into the ground only a few hundred feet from a drilled well which served as the source of water for the school. It was therefore hypothesized that contaminated drinking water was the source of infection. After correction of the drainage problem and liberal use of gamma globulin in school students, the epidemic subsided.

Since no vaccine is available which can initiate an active immunity against infectious hepatitis, prevention must be based on good sanitation and personal cleanliness. During an outbreak the judicious use of gamma globulin is indicated as an effective means of control.


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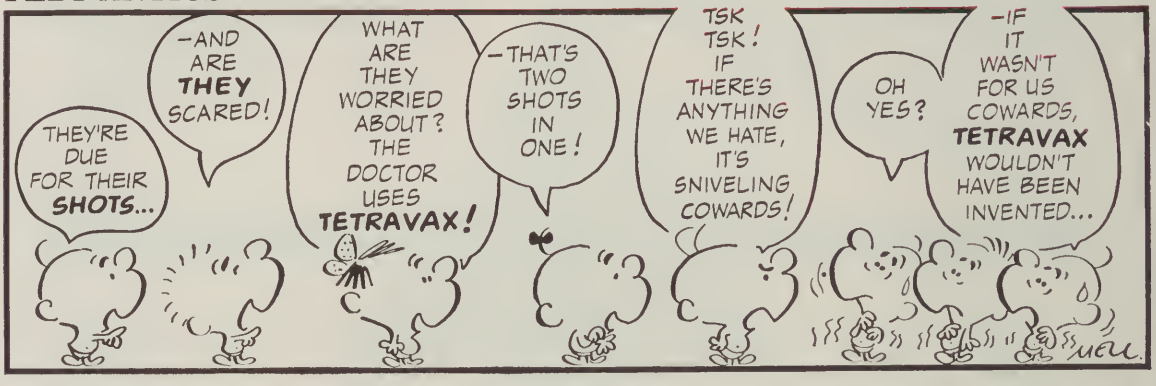
1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

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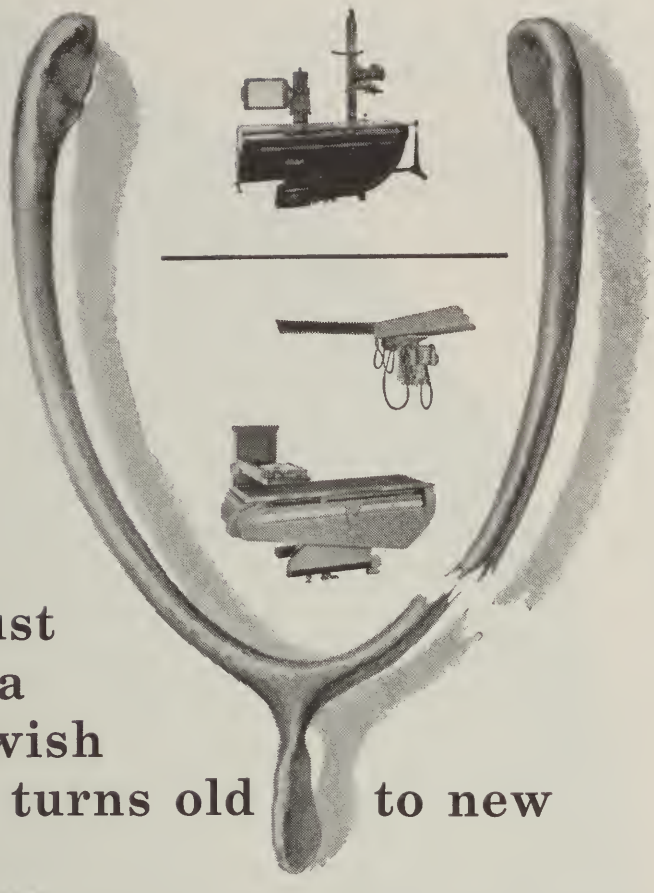
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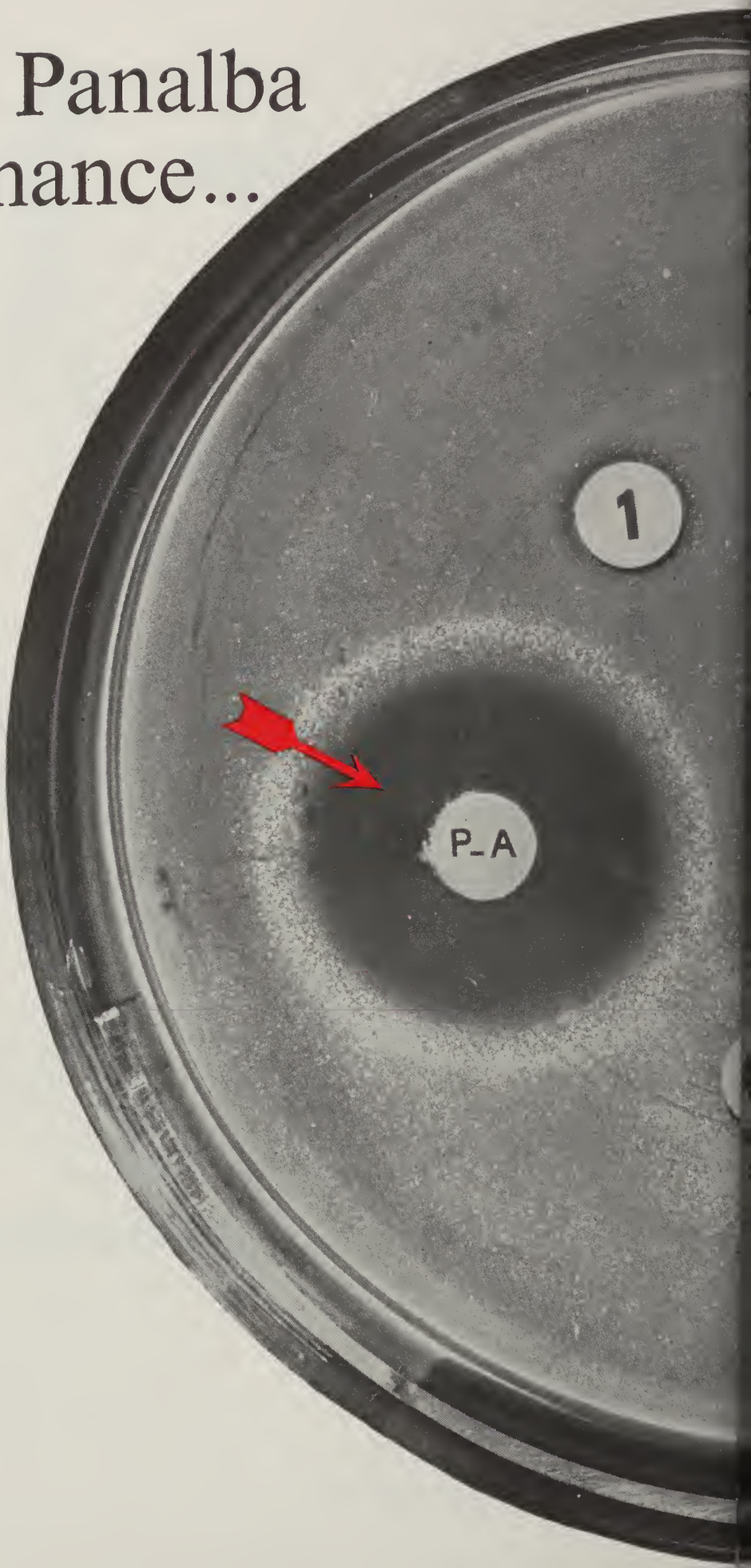
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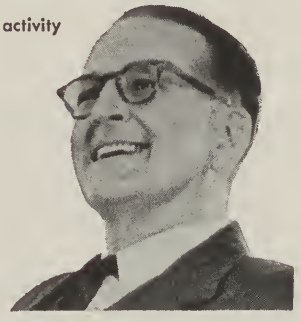
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REFERENCES:

1-11. Papers read at Seventh Symposium on Antibiotics, Washington, D. C., November 4-6, 1959.

12. Phillips, F. M.: DECLOMYCIN—Seventh Interim Report. Department of Clinical Investigation, Lederle Laboratories, Pearl River, N. Y., December 4, 1959.

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genitourinary infection. Roberts, M. S.; Seneca, H., and Lattimer, J. K.,[1] New York, N. Y.—Ninety-one per cent of the Gram-positive and 27 per cent of the Gram-negative, among 66 organisms cultured from genitourinary infection, responded to DECLOMYCIN. Serum antibiotic activity was found three times greater than with tetracycline.

toleration. Boger, W. P., and Gavin, J. J.,[2] Norristown, Pennsylvania—Side effects with DECLOMYCIN were minimal. When dosage was 0.5 to 1 Gm. daily in divided doses, only two of 82 patients exhibited nausea.

activity level sustentation. Kunin, C. M.; Dornbush, A. C., and Finland, M.,[3] Boston, Massachusetts—Of the four tetracycline analogues, DECLOMYCIN Demethylchlortetracycline showed the longest sustained activity levels in the blood.

gonococcal infection. Marmell, M., and Prigot, A.,[4] New York, N. Y.—Of 63 cases of gonorrhea, 61 promptly responded after short courses of DECLOMYCIN. Therapeutic effect was found equal to that of intramuscular penicillin.

bronchopulmonary infection. Perry, D. M.; Hall, G. A., and Kirby, W. M. M.,[5] Seattle, Washington—Of 30 cases of acute bacterial pneumonia, all were afebrile following two to 10 days of treatment with DECLOMYCIN. Results were good in 21.... All of six patients with acute bronchitis responded promptly.

pediatric infection. Fujii, R.; Ichihashi, H.; Minamitani, M.; Konno, M., and Ishibashi, T.,[6] Tokyo, Japan—In 309 pediatric patients with various infections, DECLOMYCIN was effective in 75 per cent.

urogenital infection. Vineyard, J. P.; Hogan, J., and Sanford, J. P.,[7] Dallas, Texas—Clinical response in pyelonephritis correlated well with results of *in vitro* sensitivity tests, which showed some strains of *A. aerogenes*, Proteus and Pseudomonas more susceptible to DECLOMYCIN Demethylchlortetracycline than to its analogues.

pneumonia. Duke, C. J.; Katz, S., and Donohoe, R. F.,[8] Washington, D. C.—Results were satisfactory in all but two of 32 cases of acute bacterial pneumonia, of which only 11 were uncomplicated. No side effects were observed.

brucellosis. Chávez Max G.,[9] Mexico, D. F., Mexico—All of nine patients with *Br. melitensis* infection were afebrile after five days on DECLOMYCIN. Blood cultures were negative in all cases on the 20th day. Side effects were limited to slight temperature increases which abated in four days.

pustular dermatosis. Blau, S., and Kanof, N. B.,[10] New York, N. Y.—Results with DECLOMYCIN were excellent in both of two cases of impetigo, one of two cases of folliculitis, six of nine cases of furunculosis, all of three cases of acne rosacea and 26 of 45 cases of acne vulgaris. Overall, results were excellent or good in 85 per cent.

antibacterial spectrum. Finland, M.; Hirsch, H. A., and Kunin, C. M.,[11] Boston, Massachusetts—DECLOMYCIN Demethylchlortetracycline was found the most effective of the tetracycline analogues against two-thirds of 680 normally sensitive strains of 15 separate species.

the over-all picture. Combined results reported by 210 clinical investigators[12]—DECLOMYCIN produced a favorable response (cured or improved) in 87 per cent of 1,904 patients. Two-thirds of the patients received one capsule every six hours. Treatment was continued for as long as 180 days, but was between three and eight days in most. Side effects were seen in 9.9 per cent, but necessitated discontinuance of treatment in only 1.8 per cent.

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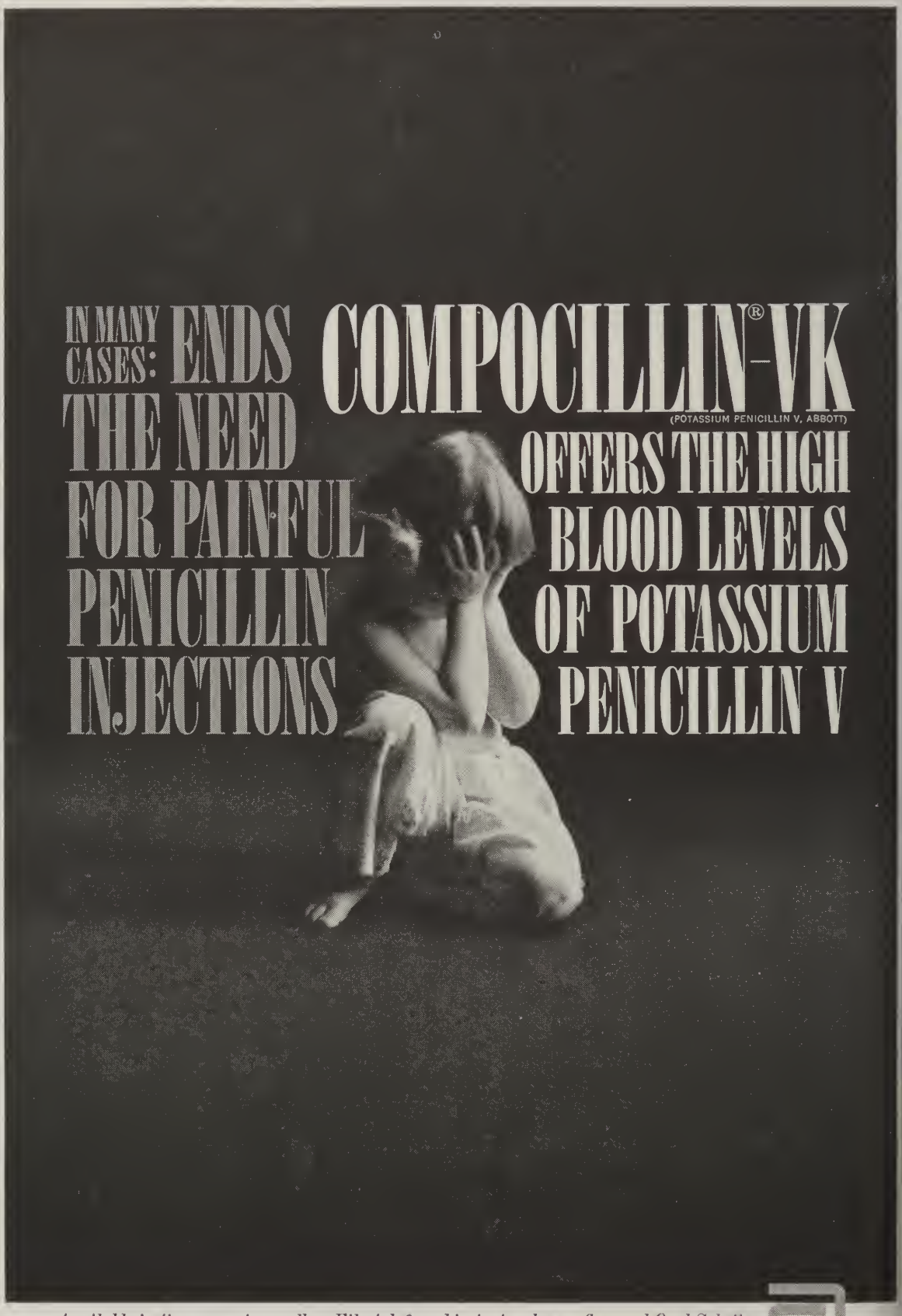
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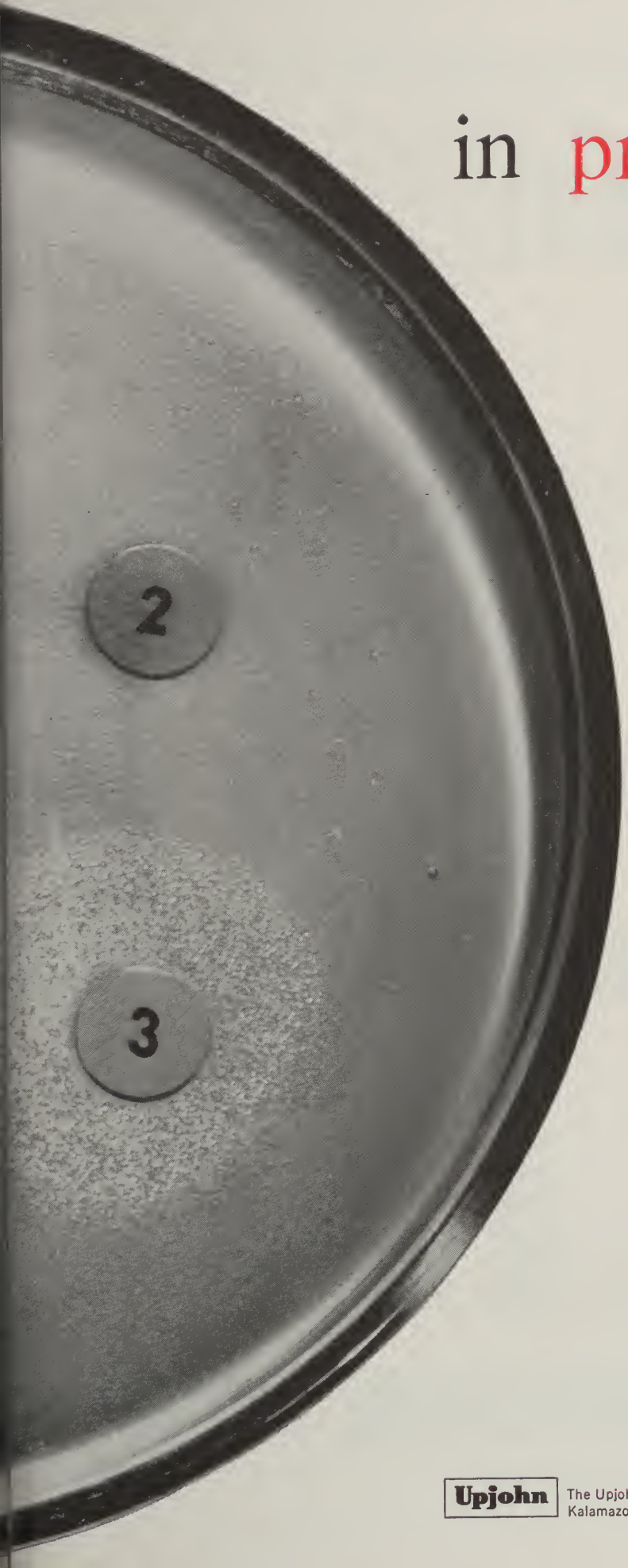
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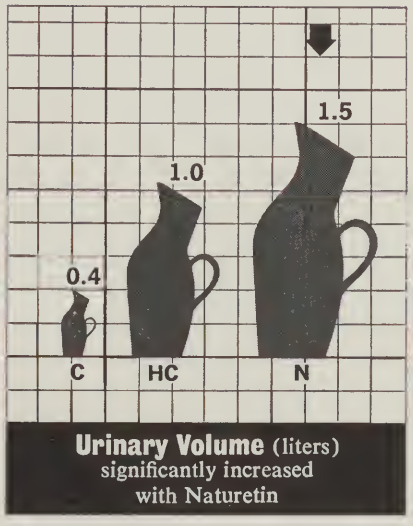
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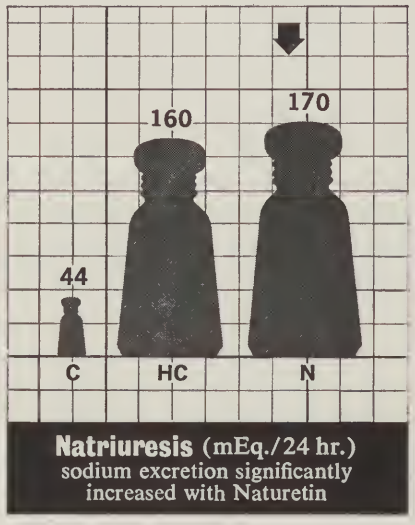
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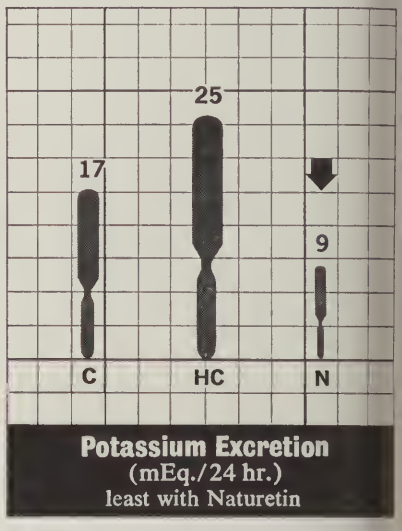
Comparison of electrolyte excretion pattern for the 24 hours following typical doses of chlorothiazide, hydrochlorothiazide, and Naturetin[1]



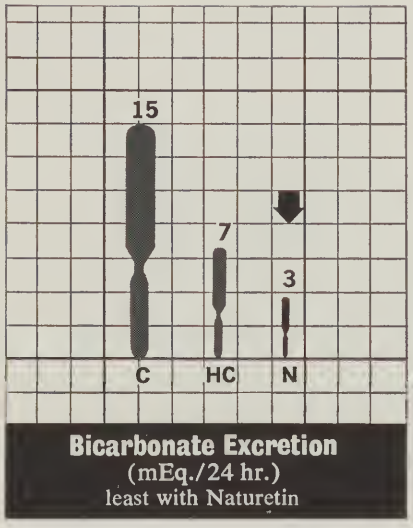
Urinary Volume (liters) significantly increased with Naturetin



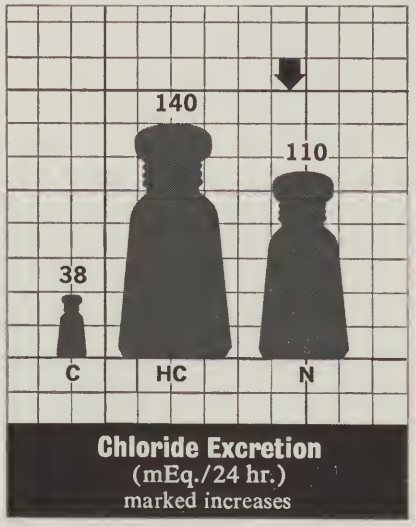
Natriuresis (mEq./24 hr.) sodium excretion significantly increased with Naturetin



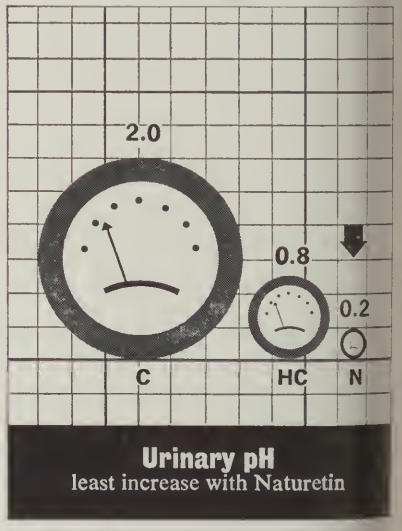
Potassium Excretion (mEq./24 hr.) least with Naturetin



Bicarbonate Excretion (mEq./24 hr.) least with Naturetin



Chloride Excretion (mEq./24 hr.) marked increases



Urinary pH least increase with Naturetin

Typical Doses: Chlorothiazide—1,000 mg.; Hydrochlorothiazide—50 mg.; Naturetin (Benzydroflumethiazide)—5 mg.

1. Adapted from: Ford, R. V., Squibb Clin. Res. Notes 2:1 (Dec.) 1959.

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- in hypertension, Naturetin, alone or in combination with other antihypertensives, produces significant decreases in mean blood pressure and other favorable clinical effects
- purpura and agranulocytosis not observed
- allergic reactions rarely observed

[2]Reports (1959) to the Squibb Institute for Medical Research.

Naturētin —*Indications:* in control of edema when diuresis is required, in congestive heart failure, in the premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs (certain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb Rauwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

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Naturētin —*Dosage: in edema,* average dose, 5 mg., once daily, preferably in the morning; to initiate therapy, up to 20 mg., once daily or in divided doses; for maintenance, 2.5 to 5.0 mg., daily in a single dose. *In hypertension:* suggested initial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending on the individual response of the patient. When Naturetin is added to an antihypertensive regimen with other agents, lower maintenance doses of each drug should be used.

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Public Relations

The opinion is widely and correctly held that the individual physician is his best Public Relations Agent. This point of view has been firmly substantiated by surveys which show that the individual citizen holds in high regard and esteem those physicians with whom he is personally acquainted. The same surveys have also shown that this same individual citizen may, and frequently does, entertain an entirely different type of regard for other physicians and for the medical profession as a whole.

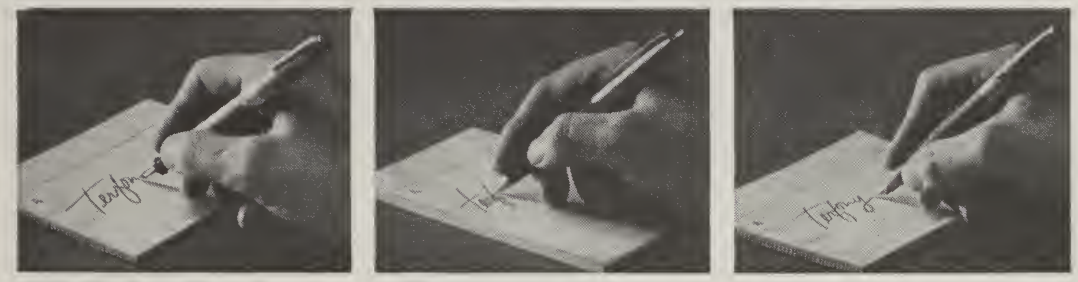
In smaller communities where the four or five physicians are known to all the population both by name and by reputation, it is agreed that a public relations effort would be wasteful of time and energy. However, in a metropolitan area where the 750 physicians know each other by name only, if at all; and where no single physician enjoys more than a reputation amongst the 650,000 citizens, a problem does exist. If this problem is considered in terms of a state with 3,000,000 people, it rapidly enhances in scope.

The image that people have of the profession as a whole is far more favorable than unfavorable, but there are facets of this image which contain negative elements of some dimension. Such facets are currently located in the fields of human relations, professional integrity, satisfaction with service, doctor-to-public communications, financial arrangements, and interest in community and public affairs.

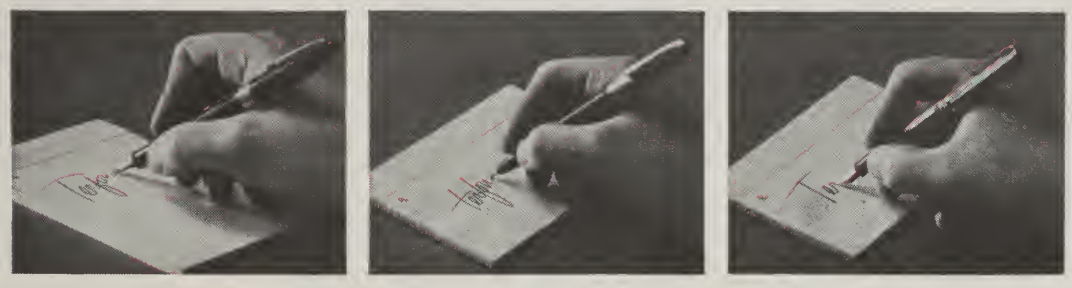
The individual physician continues to enjoy the respect, loyalty and affection of his own patients. However, there are now 180,000 physicians and 180,000,000 people in this country; and all of those people must understand each other in terms of the entire group.

If Public Relations are not of immense value, the large business corporations in this country are yearly expending hundreds of thousands of dollars futilely and stupidly.

Louis Abell Jr.



more and more physicians are prescribing this triple sulfa



TERFONYL

Squibb Triple Sulfas (Trisulfapyrimidines)

Clinical experience continues to prove that TERFONYL provides many special advantages fundamental to successful antibacterial therapy.

• specificity for a wide range of organisms • superinfection rarely encountered • soluble in urine through entire physiologic pH range • minimal disturbance of intestinal flora • excellent diffusion throughout tissues • readily crosses blood-brain barrier • sustained therapeutic blood levels • extremely low incidence of sensitization

SUPPLY: Tablets, 0.5 gm. • Suspension, raspberry flavored, 0.5 gm. per teaspoonful (5cc.).

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the mood brightener

eases mental adjustment to menopause

NIAMID brightens the outlook of depressed menopausal patients — gradually helps them become alert, cheerful, relaxed, and better able to cope with their surroundings.

Start with 75 to 100 mg. of NIAMID daily and adjust according to response. In routine use, up to 200 mg. is given. The gradual response to NIAMID may be noted within several days or weeks.

Infrequent, mild side effects may occur but often are lessened or eliminated by dosage reduction. NIAMID has *not* been reported to cause jaundice, disturbances of color vision, ankle edema, or skin eruptions.

NIAMID (brand of nialamide) is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

Already prescribed for more than 500,000 patients.

A Professional Information Booklet is available on request from the Medical Department, Pfizer Laboratories, Div., Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

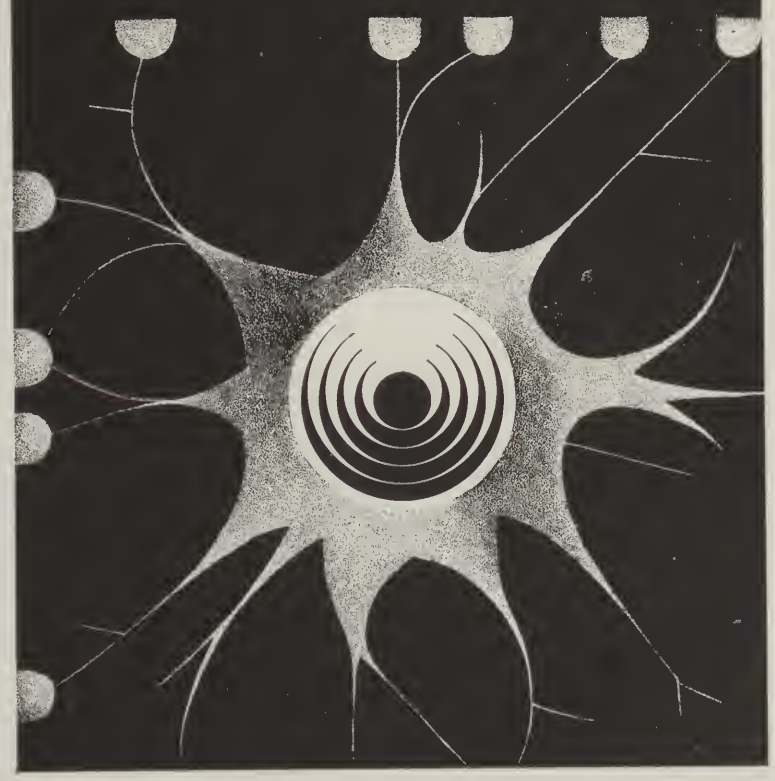
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lights the road to recovery in 80 per cent of cases



In the treatment of depression Tofrānil has established the remarkable record of producing remission or improvement in approximately 80 per cent of cases.[1-7]

Tofrānil is well tolerated in usage—is adaptable to either office or hospital practice—is administrable by either oral or intramuscular routes.

Tofrānil
a potent thymoleptic... not a MAO inhibitor.

Does act effectively in *all* types of depression regardless of severity or chronicity.

Does not inhibit monoamine oxidase in brain or liver; produce CNS stimulation; or potentiate other drugs such as barbiturates and alcohol.

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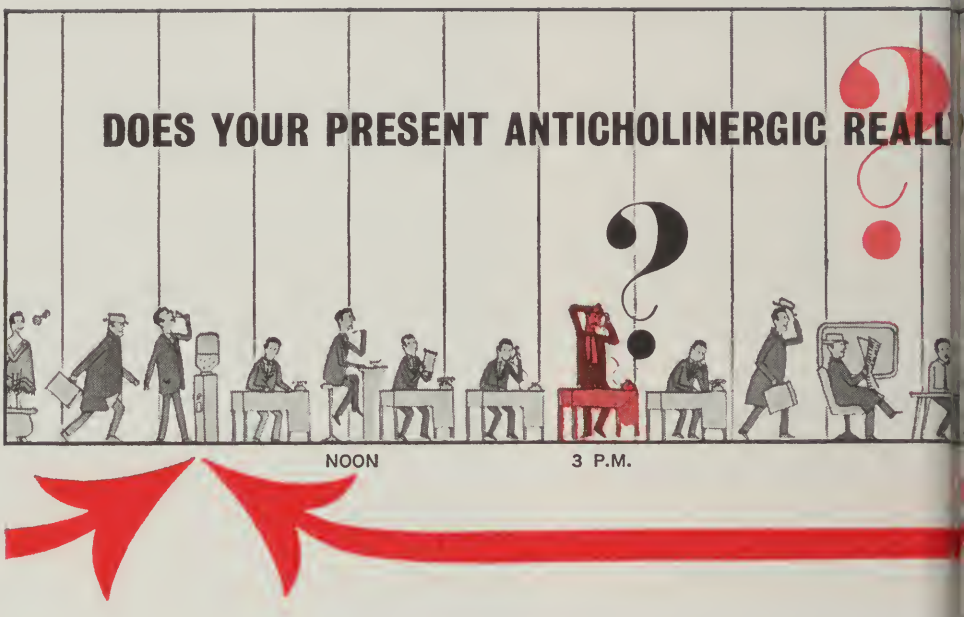
Tofrānil® brand of imipramine HCl: tablets of 25 mg., bottles of 100. Ampuls for intramuscular administration only, each containing 25 mg. in 2 cc. of solution, cartons of 10 and 50.

References: 1. Ayd, F. J., Jr.: Bull. School Med., Univ. Maryland *44*:29, 1959. 2. Azima, H., and Vispo, R. H.: A.M.A. Arch. Neurol. & Psychiat. *81*:658, 1959. 3. Lehmann, H. E.; Cahn, C. H., and de Verteuil, R. L.: Canad. Psychiat. A. J. *3*:155, 1958. 4. Mann, A. M. and MacPherson, A. S.: Canad. Psychiat. A. J. *4*:38, 1959. 5. Sloane, R. B.; Habib, A., and Batt, U. E.: Canad. M.A.J. *80*:540, 1959. 6. Straker, M.: Canad. M.A.J. *80*:546, 1959. 7. Strauss, H.: New York J. Med. *59*:2906, 1959.

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Geigy

TO4-60



The test—you might say the acid test—of an anticholinergic is simple: will it protect your patient from hyperacidity around the clock, **even while he sleeps.** The weakness of t.i.d. or q.i.d. preparations is well recognized; but even some "b.i.d." encapsulations may be unreliable. McHardy, for instance, found a "widely variable duration of action, definitely less than that anticipated" in the "sustained," "delayed," and "gradual release" anticholinergics he studied.[1]

COMPARE THE DATA ON ENARAX... the new combination of an **inherently** long-acting anticholinergic (oxyphencyclimine) and Atarax, the non-secretory tranquilizer. Note the effectiveness of oxyphencyclimine:

OBSERVE THE OXYPHENCYCLIMINE REPORTS...

McHardy: "[Oxyphencyclimine] has proved to be an excellent sustained-action anticholinergic in our study of this agent over a period of eighteen months."[1]

Kemp: "...for the majority of patients, one tablet every 12 hours provided adequate control. This characteristic long action...may constitute an advantage of this drug as compared to coated 'long-acting' preparations of other compounds."[3]

Add Atarax to this 12-hour anticholinergic. The resulting combination—ENARAX—now gives relief from emotional stress, in addition to a reduction of spasm and acid. Atarax does not stimulate gastric secretion. No serious adverse clinical reaction has ever been documented with Atarax.

LOOK AT THE RESULTS WITH ENARAX[4,5]:

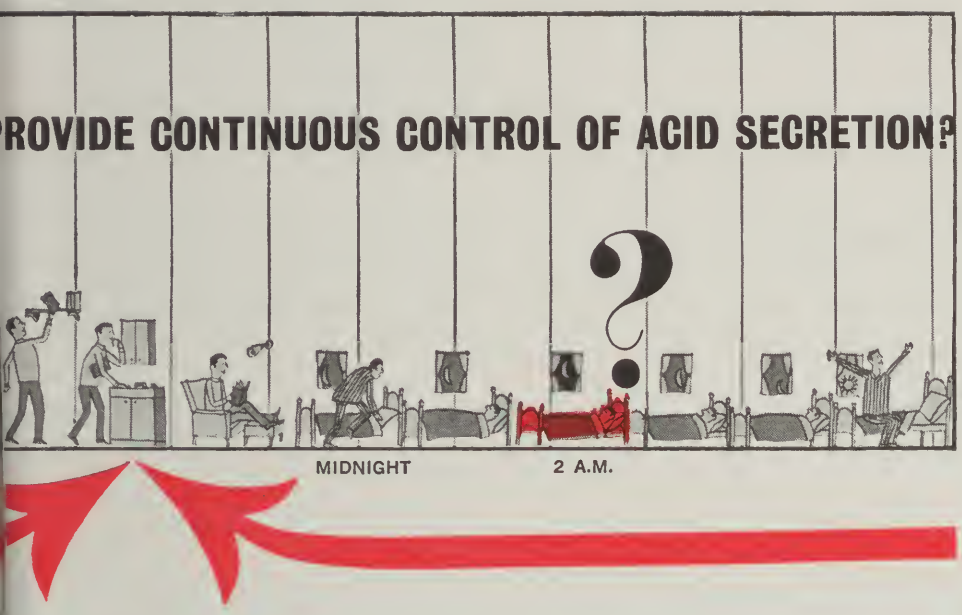
Does the medication you now prescribe assure you of all these benefits? If not, why not put your next patient with peptic ulcer or G.I. dysfunction on therapy that **does.**

ENARAX®

(oxyphencyclimine plus ATARAX®)

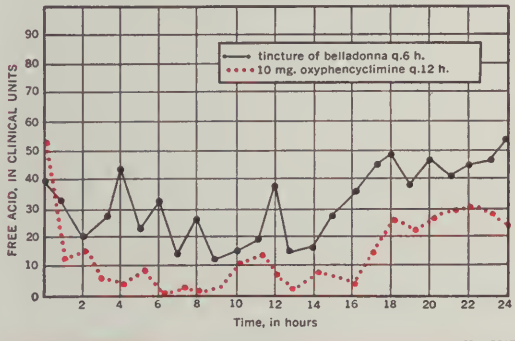
A SENTRY FOR THE G.I. TRACT

ROVIDE CONTINUOUS CONTROL OF ACID SECRETION?



"Prolonged periods of achlorhydria" after 10 mg. oxyphencyclimine q. 12 h.[3]

MEAN GRAPH OF GASTRIC ACIDITY IN 4 PATIENTS RECEIVING COMPLETE THERAPEUTIC REGIMEN • 24-HOUR STUDY



Clinical Diagnosis: Peptic Ulcer—Gastritis—Gastroenteritis—Colitis—Functional Bowel Syndrome—Duodenitis—Hiatus Hernia (symptomatic)—Irritable Bowel Syndrome—Pylorospasm—Cardiospasm—Biliary Tract Dysfunctions—and Dysmenorrhea.

Clinical Results: Effective in over 92% of cases.

As for Safety: "Side reactions were uncommon, usually no more than dryness of the mouth...."[4]

Each ENARAX tablet contains:

Oxyphencyclimine HCl ..... 10 mg.
Hydroxyzine (ATARAX®) ..... 25 mg.

Dosage: One-half to one tablet twice daily—preferably in the morning and before retiring. The maintenance dose should be adjusted according to therapeutic response. Use with caution in patients with prostatic hypertrophy and with ophthalmological supervision only in glaucoma.

Supplied: In bottles of 60 black-and-white scored tablets.

References: 1. McHardy, G., et al.: J. Louisiana M. Soc. 111:290 (Aug.) 1959. 2. Steigmann, F.: Study conducted at Cook County Hospital, Chicago, Illinois, in press. 3. Kemp, J. A.: Antibiotic Med. & Clin. Therapy 6:534 (Sept.) 1959. 4. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 5. Data in Roerig Medical Department files.

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IN *ORAL* CONTROL OF PAIN

ACTS FASTER—usually within 5-15 minutes. **LASTS LONGER**—usually 6 hours or more. **MORE THOROUGH RELIEF**—permits uninterrupted sleep through the night. **RARELY CONSTIPATES**—excellent for chronic or bedridden patients.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Also available — for greater flexibility in dosage — PERCODAN®-DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

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Percodan® *Tablets*

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

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for the tense and nervous patient

relief comes fast and comfortably

–does not produce autonomic side reactions
–does not impair mental efficiency, motor control, or normal behavior.

Usual Dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*—400 mg. *unmarked,* coated tablets.

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New...conservative treatment for muscle and joint disease

- potent...fast relief in acute conditions
- safe...even for prolonged use in chronic cases

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bursitis

strains and sprains

traumatic conditions

arthritis

myalgias



SOMA RELIEVES PAIN in a unique way by modifying central perception of pain without abolishing natural defense reflexes.

SOMA RELAXES MUSCLE SPASM . . . approximately 8 times more potent than meprobamate or mephenesin.

PHYSICIANS' REPORTS: "Marked pain-relieving effects of the new drug [SOMA] were seen in conditions involving muscle spasm and stiffness, whether acute or chronic. Relief from pain was usually rapid and sometimes dramatic." (90 patients.)
Kuge, T.: Submitted for publication.

"In 86 percent of the patients there were excellent or good results. . . . Relief of pain was noted by the patients' statements, by the diminished need for analgesic drugs, and by improved sleep." (154 patients.)
Wein, A. B.: The Use of Carisoprodol in Orthopedic Surgery and Rehabilitation. Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol. Wayne State University Press, Detroit, 1959, p. 156.

In a double-blind study, SOMA was reported to be "clinically effective to a highly significant degree." (92 patients.)
Cooper, C. D., and Epstein, J. H.: The Clinical Evaluation of Carisoprodol by a double-blind technique. Ibid. p. 97.

Notable safety—extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosage

Rapid action—starts to act quickly

Sustained effect—relief lasts up to 6 hours

Easy to use—usual adult dose is one 350 mg. tablet 3 times daily and at bedtime

Supplied—as white, coated, 350 mg. tablets, bottles of 50.
Also available for pediatric use: 250 mg. orange capsules, bottles of 50.

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BIBLIOGRAPHY: 1. Berger, F.M., Kletzkin, M., Ludwig, B.J., Margolin, S. and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 2. Leake, Chauncey D.: Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959, p. 8. 3. Kestler, Otto: Ibid. p. 143. 4. Proctor, Richard C.: Ibid. p. 122. 5. Berger, Frank M., Ibid. p. 25. 6. Goodgold, Joseph, Hohmann, Thomas and Tajima, Toshihiro: Ibid. p. 66. 7. Gammon, George D. and Tucker, Samuel: Ibid. p. 70. 8. Baird, Henry W. and Menta, Dominic A.: Ibid. p. 85. 9. Cooper, C. David and Epstein, Jerome H.: Ibid. p. 97. 10. Korst, Donald R., Gerard, R. W., Miller, James G., Small, Iver F., Graham, I. J. and Winkelman, Eugene I : Ibid. p. 104. 11. Friedman, Arnold P.: Ibid. p. 115. 12. Trimpi, Howard D.: Ibid. p. 150. 13. Wein, Artbur B.: Ibid. p. 156. 14. Olds, James and Travis, R. P.: Ibid. p. 39. 15. Hess, Eckhard H., Polt, James M. and Goodwin, Elizabeth: Ibid. p. 51. 16. Phelps, Winthrop M.: Ibid. p. 131. 17. Spears, Catherine E.: Ibid. p. 138. 18. Hyde, L. P. and Hough, Charles E.: Ibid. p. 166. 19. Spears, Catherine E. and Phelps, Winthrop M.: Arch Pediat., *76*:287 (July) 1959. 20. Phelps, Winthrop M.: Arch. Pediat., *76*:243 (June) 1959. 21. Friedman, Arnold P.: Paper presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 22. Frankel, Kalman: Ibid. 23. Fransway, Robert L.: Ibid. 24. Kuge, T.: Unpublished reports.

Literature and samples on request WALLACE LABORATORIES, New Brunswick, New Jersey

Q.

When you want to prescribe a regimen to reduce serum cholesterol and beta lipoproteins, are drastic diet changes necessary?

a.

Fortunately, no. Often only two steps are necessary: (1) control of the amount of calories and of dietary fat, and

(2) a simple modification of food preparation method in which poly-unsaturated vegetable oil is used in place of saturated fats.

Obviously, in any special diet, the fewer required changes in the patient's eating habits, the more likelihood there is that the patient will adhere to the prescribed diet.

Once total fat and calorie intake is adjusted, the simple replacement of *saturated* fats, used at the table and in cooking, with *poly*-unsaturated Wesson makes possible a most subtle dietary change, yet conforms completely to therapeutic requirements.

Where a vegetable (salad) oil is medically recommended as part of a cholesterol depressant regimen, Wesson is unsurpassed by any readily available brand.

Uniformity you can depend on. Wesson has a poly-unsaturated content better than 50%. Only the lightest cottonseed oils of highest iodine number are selected for Wesson and no significant variations in standards are permitted in the 22 exacting specifications required before bottling.



This flaky pie crust, *crisp cookies, Chiffon cakes, biscuits can all be made easily with Wesson. Decrease the calories of pie by preparing with single crust and a fresh fruit or gelatin filling. It is delicious.*

FREE *Wesson recipes are available in quantity for your patients, showing them how to prepare these treats as well as main dishes, vegetables and salads with poly-unsaturated vegetable oil. Request quantity needed from The Wesson People, Dept. N., 210 Baronne St., New Orleans 12, La.*



Wesson satisfies the most exacting appetites. To be effective, a diet must be *eaten* by the patient. The majority of housewives prefer Wesson particularly by the criteria of odor, flavor (blandness) and lightness .of color. (Substantiated by sales leadership for 59 years and reconfirmed by recent tests against the next leading brand with brand identification removed, among a national probability sample.)

Wesson's Important Constituents

Wesson is 100% cottonseed oil . . . winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	19-28%
Total unsaturated	75-80%
Palmitic and stearic glycerides (saturated)	20-25%
Phytosterol (predominantly beta sitosterol)	0.4-0.7%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Each pint of Wesson contains 437-524 Int. Units of Vitamin E.

The Ides of Taxes Are Upon You

April 15, 1960, will be a red letter day for millions of Americans, as it is the deadline for filling Federal Income Tax Returns. For Kentuckians, it is doubly significant as it is also the final date for filing state returns.

However, this is nothing new to most of us, as the Federal Income Tax laws have been with us since 1913. Prior to that, the collection of customs and tariffs primarily financed governmental operation. Interesting to note, these collections now total only 6% of the amount necessary to run the government.

Income taxes are just one of the many now imposed upon the self-employed who have various personnel working either for them or under their supervision. First of all, we have the Social Security taxes which for 1960 have been increased to 3% for the employer and 3% for the employee, or total rate of 6% on the first $4,800 of wages paid on or after January 1, 1960.

First of a Series

This is the first of a series of articles on taxes that will appear quarterly in the KSMA Journal during the coming year. Forthcoming articles will deal mainly with the tax aspects of everyday transactions. As the information presented must necessarily be general in nature, it is suggested that expert advice should be sought where real tax problems are concerned. The Tax Page is being written by William E. Rudd, KSMA Executive Assistant, who formerly was an Internal Revenue Agent, examining officer for the Bureau of Internal Revenue.

Secondly, there are unemployment taxes. The individual employer is required to shoulder the burden of these costs, as no contributions are made by the employees. The combination Federal and State rate is 3%. All physicians having four or more employees on at least one day of each of 20 weeks in the calendar year are subject to these provisions.

Additionally, all physicians having three or more employees are subject to the jurisdiction of Workmen's Compensation, which is designed to provide a fund to pay compensation to employees injured in line of duty or work.

One note of warning!! Do you or your wife employ household help in your private home? If so, and if you pay the employee $50 or more in cash wages in a quarter, you are subject to Social Security provisions for such employees. Failure to comply can prove costly.

Status Of Return After Filing

After this briefing on required taxes, it might be well to scan the status of the Federal Income Tax Return after it is filed. All Federal returns filed by residents of Kentucky are mailed to Louisville, where they are processed, verified and checked for mathematical accuracy. If the return denotes an over-assessment or deficiency, the necessary accounting procedure is set in motion.

Next, the returns are filed numerically and also in three general classifications according to net taxable income. We understand the breakdowns in net taxable income now in use are: (1) Under $10,000; (2) $10,000 to $30,000; (3) over $30,000.

A return filed by April 15, 1960, under the general rule requires an assessment of taxes within a period of three years. This is exclusive of fraud and the 25% understatement of gross income. This means the Government would have until April 15, 1963, to assess or refund you additional money on your 1959 tax return, provided the above exclusions do not apply.

Suppose your return is pulled by one of the agents. Depending on the nature of the items involved, the examination could be handled by the Office Audit Division, or one of the Examining Officers could call on you personally.

Examination by office audit simply implies that you are not contacted personally by an Examining Officer, but an agent in the office calls you and either asks you to drop into the office to discuss the item in question or to mail in the supporting evidence in connection with the item. Examinations of this type are usually used by the Director of Internal Revenue when it is felt that a complete field examination is useless and would disclose no discrepancies other than the ones they are questioning.

How to Avoid Examinations

There is no way to be assured you will not be examined. But you can make sure of the mathematical accuracy of your figures when filing your return. An error on a return can lead to an examination.

Keep good records on your income and expenses, and you'll have no worry if you are examined. The examination will probably be short and painless.

William E. Rudd

Trilafon® perphenazine for the anxiety in the person overwhelmed by family illness...selective anxiety relief with minimal drowsiness or dulling

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Tetracycline Phosphate Complex (TETREX®)
U.S. PAT. NO. 2,791,609
in the Therapy of

ACUTE PHARYNGITIS, ESPECIALLY WITH LYMPHADENITIS

Ideally, selection of the proper antibiotic for treatment of acute pharyngitis should await the laboratory reports on the susceptibility of the infecting bacteria. But the busy practitioner who sees many patients a day during the upper respiratory infection season may sometimes find it difficult to avoid the empirical choice of an antibiotic. Unfortunately, this practice may sometimes result in therapeutic failure.

No matter what the pressure of the immediate situation, it is worthwhile to consider taking a bacterial specimen from the infected pharynx for culture and sensitivity studies before starting treatment. Thus, a rational basis will be provided for changing the antibiotic should the first choice prove ineffective.

Which Antibiotic?

All other things being equal, the drug of choice is the one to which the pathogen is most susceptible. But if the exigencies of the situation force the physician to a prompt use of antibiotic, a broad-spectrum preparation that produces immediate high blood levels (e.g., tetracycline phosphate complex, TETREX) probably has the best chance of controlling the pathogen.

Later, the laboratory report frequently may indicate that any one of several antibiotic agents would be equally effective against the particular microorganism in question. In such a case other factors such as frequency and severity of side effects, sensitizing potential and toxicity should be considered.

If the acute pharyngitis in question should be due to gram-negative Klebsiella[1], penicillin will be of no value, nor will erythromycin be effective. However, this organism is susceptible to tetracycline. If the pathogen should turn out to be gram-positive Streptococcus or Staphylococcus, then penicillin, erythromycin, and tetracycline may all be effective against it.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reactions. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

The tetracyclines (e.g., TETREX) have the advantages of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

Some Microorganisms Susceptible[a] *to Tetracycline* (TETREX)[b]

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; *C. diphtheriae; B. anthracis; E. coli;* Proteus; *A. aerogenes; K. pneumoniae;* Shigella; Brucella; *P. tularensis; H. influenzae; T. pallidum;* Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; *E. histolytica; D. granulomatosis.*

[a] Some strains are not susceptible.

[b] Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics, 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

High blood, body fluid, and tissue levels of active drug are quickly attained when the new phosphate preparation of tetracycline (TETREX) is used.

The semisynthetic tetracyclines have been in constant use since they were introduced in 1952. They have been proved clinically and have established themselves as safe, effective, and valuable antibiotic agents. But the final decision, the choice of agent, and the control of therapy must remain where it has always been, in the hands of the individual physician.

References: 1. Zinsser, H.: A Textbook of Bacteriology. 11th edition, New York, Appleton-Century-Crofts, 1957, p. 409. 2. Welch, H.: Lewis, C. H.; Weinstein, H. I., and Boeckman, B. B.: Severe reactions to antibiotics. A nationwide survey. Antibiotic Med. & Clin. Ther. 4:800 (December) 1957.

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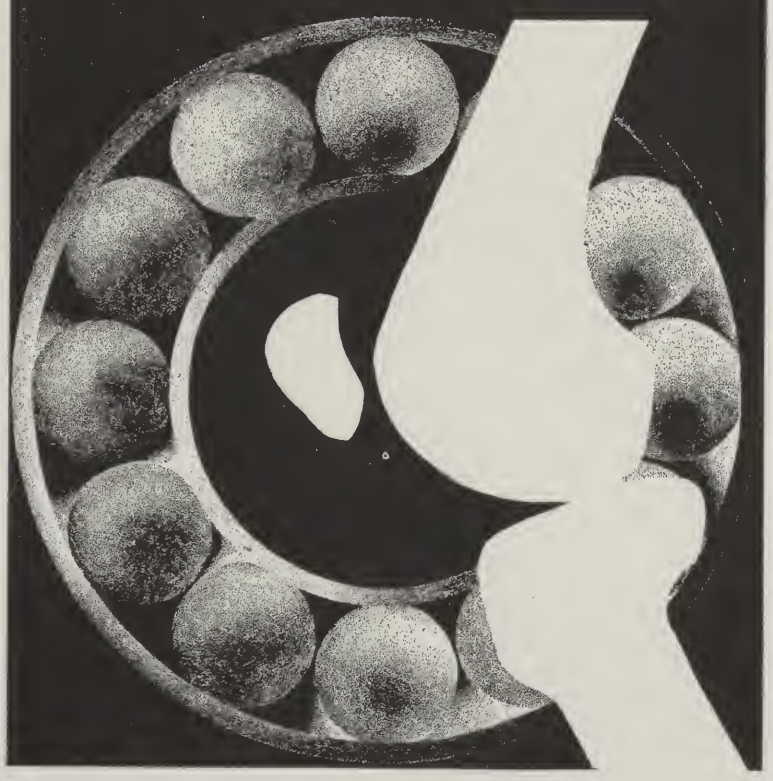
Ten years of experience in countless cases—more than 1700 published reports—have now established the eminence of Butazolidin among the potent non-hormonal antiarthritic agents.

Repeatedly it has been demonstrated that Butazolidin:
Within 24 to 72 hours produces striking relief of pain.
Within 5 to 10 days affords a marked improvement in mobility and a significant subsidence of inflammation with reduction of swelling and absorption of effusion.

Even when administered over months or years Butazolidin does not provoke tolerance nor produce signs of hormonal imbalance.

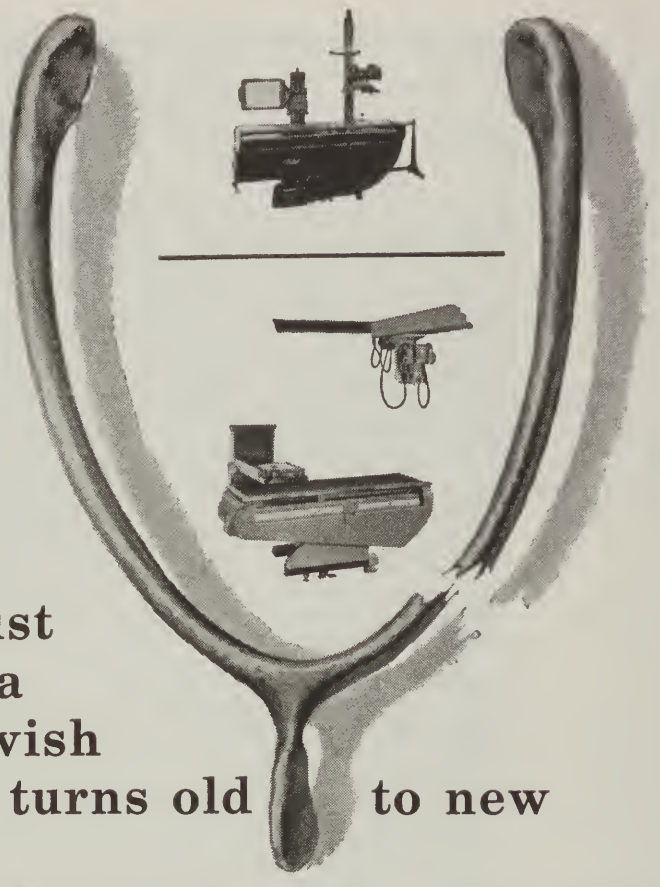
Butazolidin® brand of phenylbutazone:
Red-coated tablets of 100 mg.
Butazolidin® Alka: Capsules containing Butazolidin® 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

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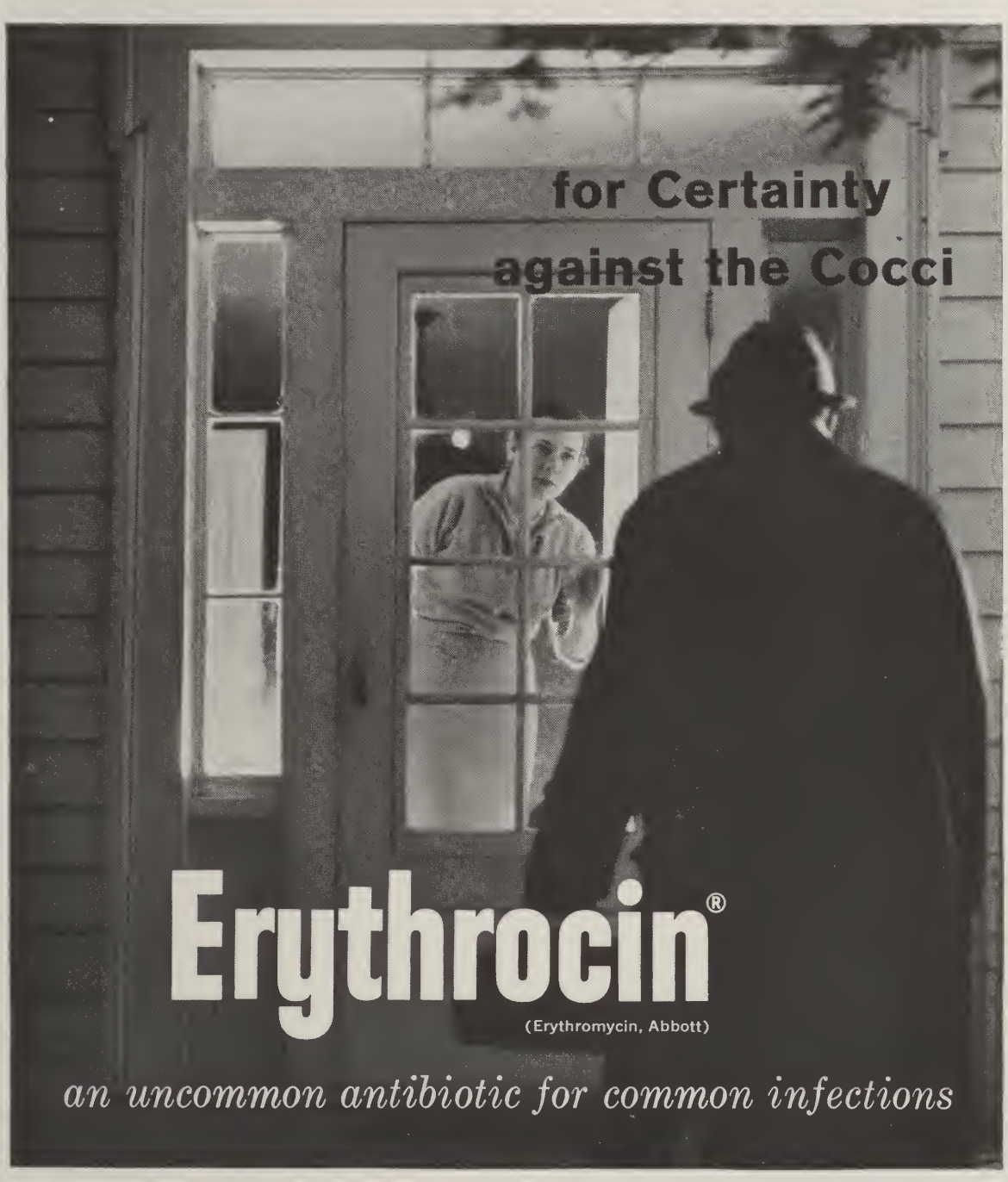
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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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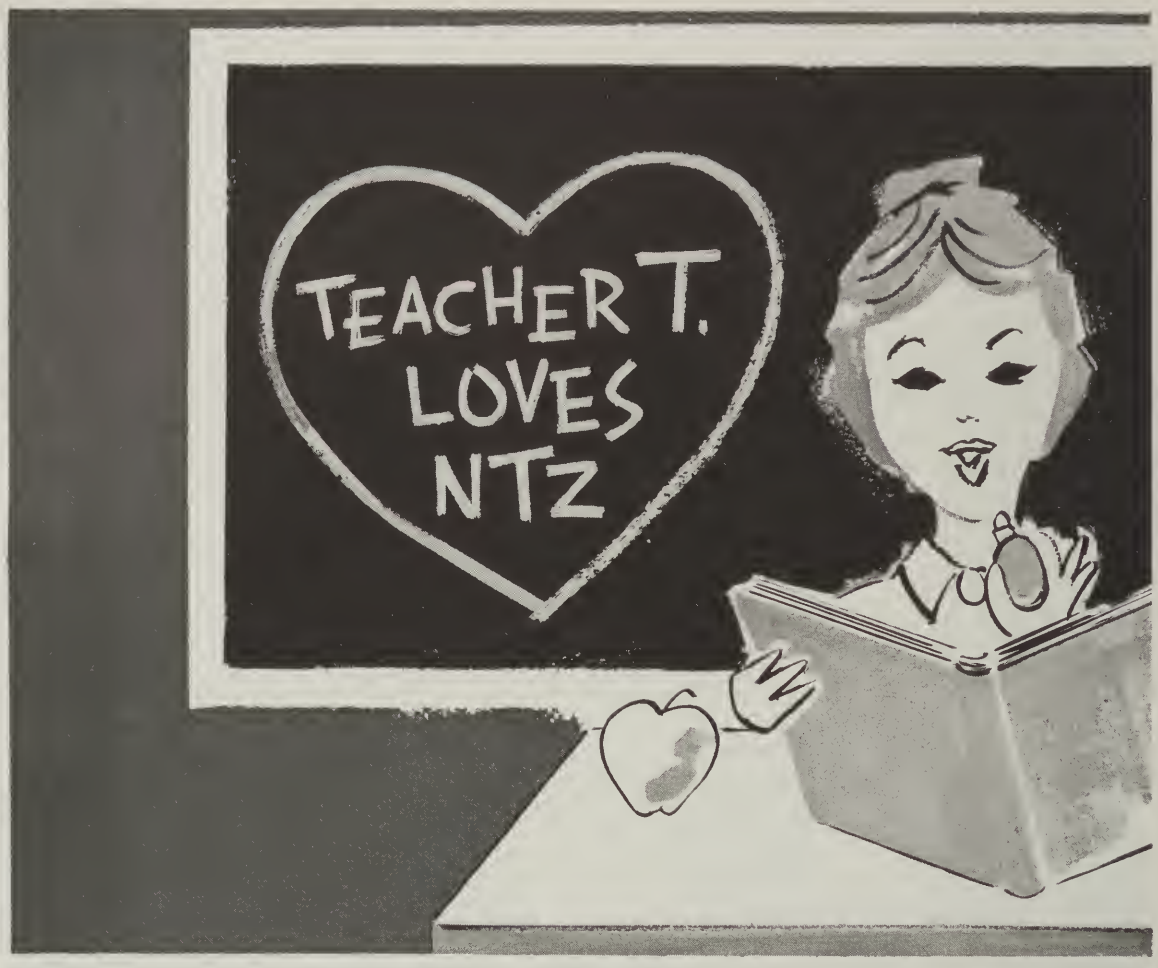


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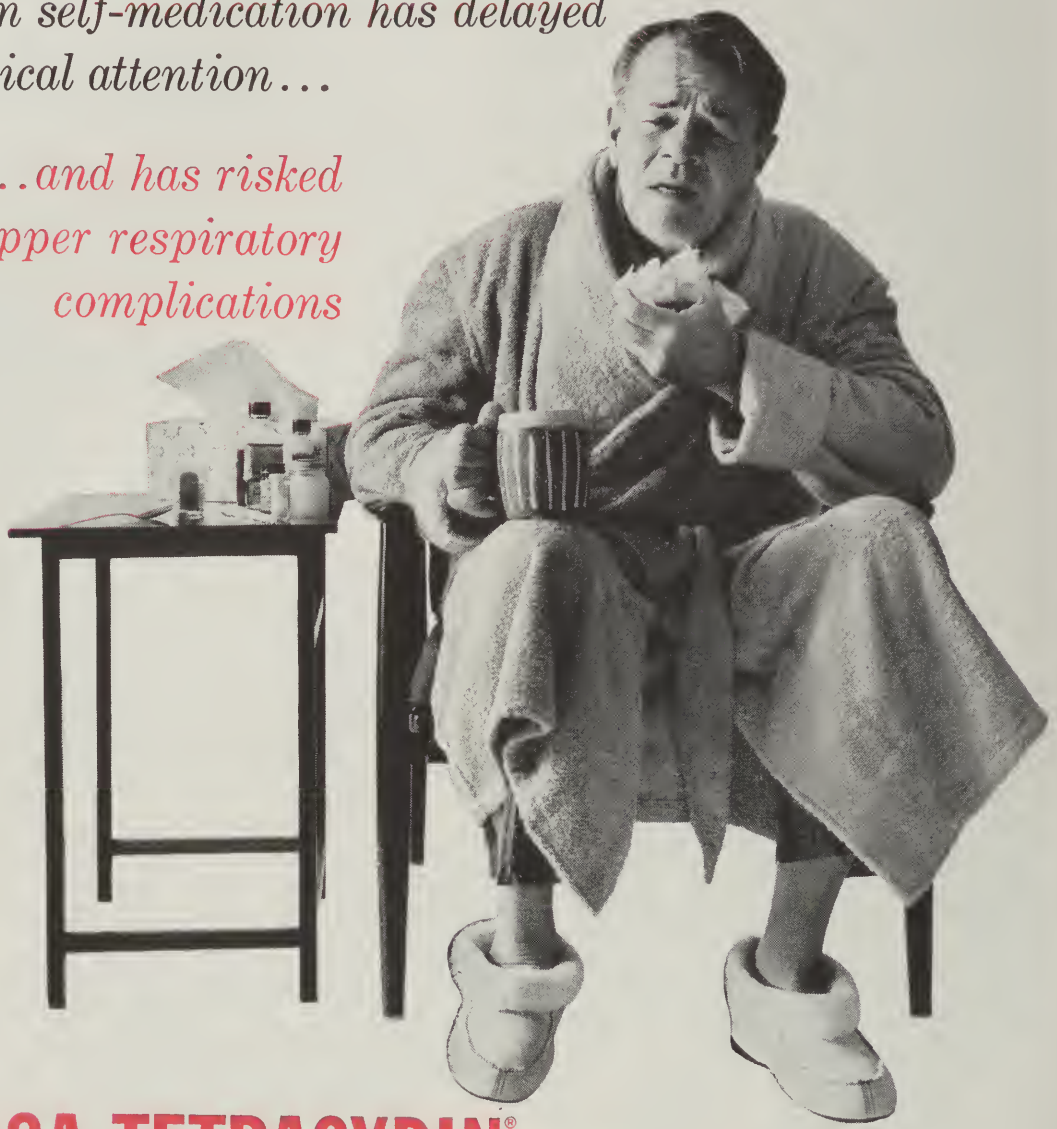
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REFERENCES: 1. Gershenfeld, L.: Am. J. Surg. *94*:938, 1957. 2. Stone, J. D., and Burnet, F. M.: Australian J. Exper. Biol. & Med. Sc. *23*:205, 1945. 3. Reddish, G. F.: Antiseptics, Disinfectants, Fungicides and Chemical and Physical Sterilization, Lea & Febiger, Philadelphia, 1954, pp. 171-211. 4. Chang, S. L., and Morris, J. C.: Engineering Chem. *45*:1009, 1953. 5. Shelanski, H. A., and Shelanski, M. V.: Polyvinylpyrrolidone-Iodine Studies Through 1951, G. A. & F. Corp. 6. Christhilf, S. M., Jr.: Personal Communication.

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WASHINGTON NEWS DIGEST



Washington, D. C.—Congress appears headed for a showdown this session on legislation for the Federal Government to provide medical care for aged persons.

The medical profession and allied groups stepped up their activities in opposition to such legislation as indications mounted that the issue was approaching a crucial stage. Several State Medical Societies planned to send delegations to Washington to express personally their opposition to their Congressmen.

Pressure behind such legislation began to build up early in February.

The Eisenhower Administration announced it was working on three possible programs for providing health care of aged persons in cases of catastrophic—lengthy and costly—illness.

Clarifying Announcement

Without amplification, President Eisenhower told a news conference that there was under consideration "a possible change" in the Social Security Act "to run up the taxes by a quarter of a per cent to . . . make greater provision for the care of the aged." The President's statement that "there has been no conclusion reached in the administration" was backed up by Arthur S. Flemming, Secretary of Health, Education and Welfare, in a clarifying announcement.

Flemming said his department was working on two other approaches to what he called a serious problem in addition to the possible revision of the Social Security law mentioned by Mr. Eisenhower. The HEW Secretary said consideration also was being given to: (1) stepped-up Federal assistance under the Federal-State public assistance program, and (2) the Federal Government supplementing voluntary insurance programs.

Flemming again expressed opposition to the Forand bill which would increase Social Security taxes by one quarter of one per cent each on employers and employees to provide hospitalization, surgical benefits and nursing home care for Social Security beneficiaries. The Secretary said he wanted to "underline that the position of the administration is opposition to the Forand bill."

Administration Bill Being Readied

Flemming said he hoped to have an administration bill ready to submit in early April to the House Ways and Means Committee where the Forand bill is pending. The Committee is scheduled to take up in late March or early April proposed changes to the Social Security Act.

Proponents of the Forand bill—which is vigorously opposed by the American Medical Association and allied groups—were pointing their campaign toward securing the House Committee's approval of the legislation at that time.

The AFL-CIO, a main supporter of the Forand bill, urged labor union members to write to Congressmen on the committee urging them to vote for it. The AFL-CIO also distributed a pamphlet quoting a handful of physicians as supporting the legislation. But the labor organization didn't mention that the overwhelming majority of doctors oppose it.

The Senate Subcommittee on Problems of the Aged and Aging, headed by Sen. Pat McNamara (D., Mich.), issued on behalf of its Democratic majority a report stating that use of the Social Security program "is the most efficient procedure for providing" health care of older persons.

The AMA and the Subcommittee's Republican minority promptly disputed this conclusion. An AMA statement issued in Chicago said:

"The American Medical Association sharply disagreed with the recommendation of the McNamara subcommittee regarding government medicine for Social Security beneficiaries.

AMA President's Statement

"Dr. Louis M. Orr, Orlando, Florida, president of the AMA, said:

" 'This is a politically inspired committee. Senator McNamara, Democrat from Michigan, has long supported political medicine. The fact is that at the seven subcommittee hearings held throughout the United States, observers heard little support expressed by the older citizens who attend the hearings for government medicine financed by additional taxes and administered through Social Security.' "

The Republican minority stated that testimony before the Subcommittee "proves that it is possible for elderly people to secure private insurance to provide hospitalization and surgical benefits without any intervention by public authorites."

Sen. John F. Kennedy (D., Mass.), a leading contender for the Democratic nomination for President, introduced legislation similar to the controversial Forand bill but broader in scope. The Kennedy bill would eliminate surgical benefits but would add diagnostic outpatient and home nursing services.



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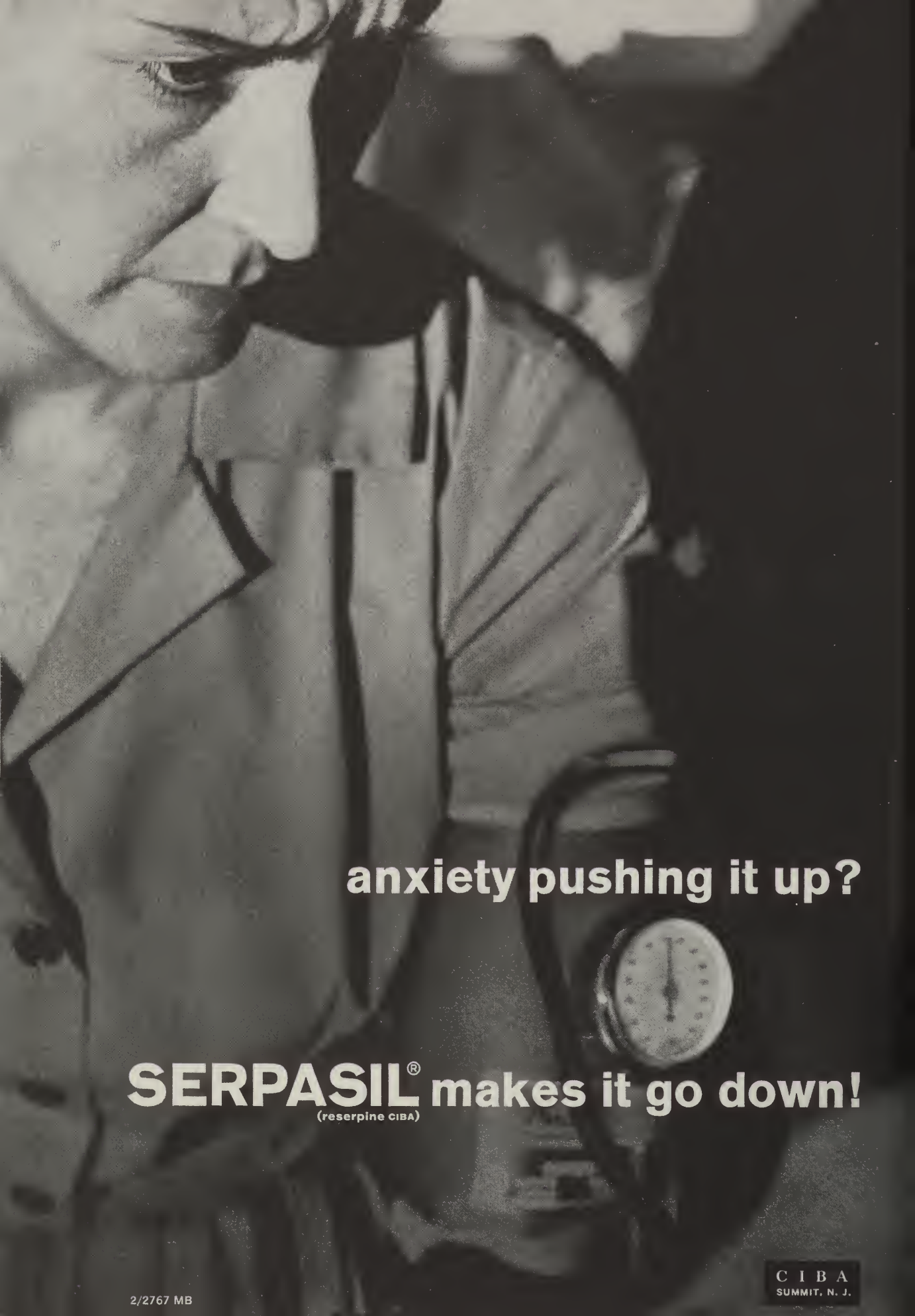
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*Peterman, R. A.: Clinical report cited with permission.

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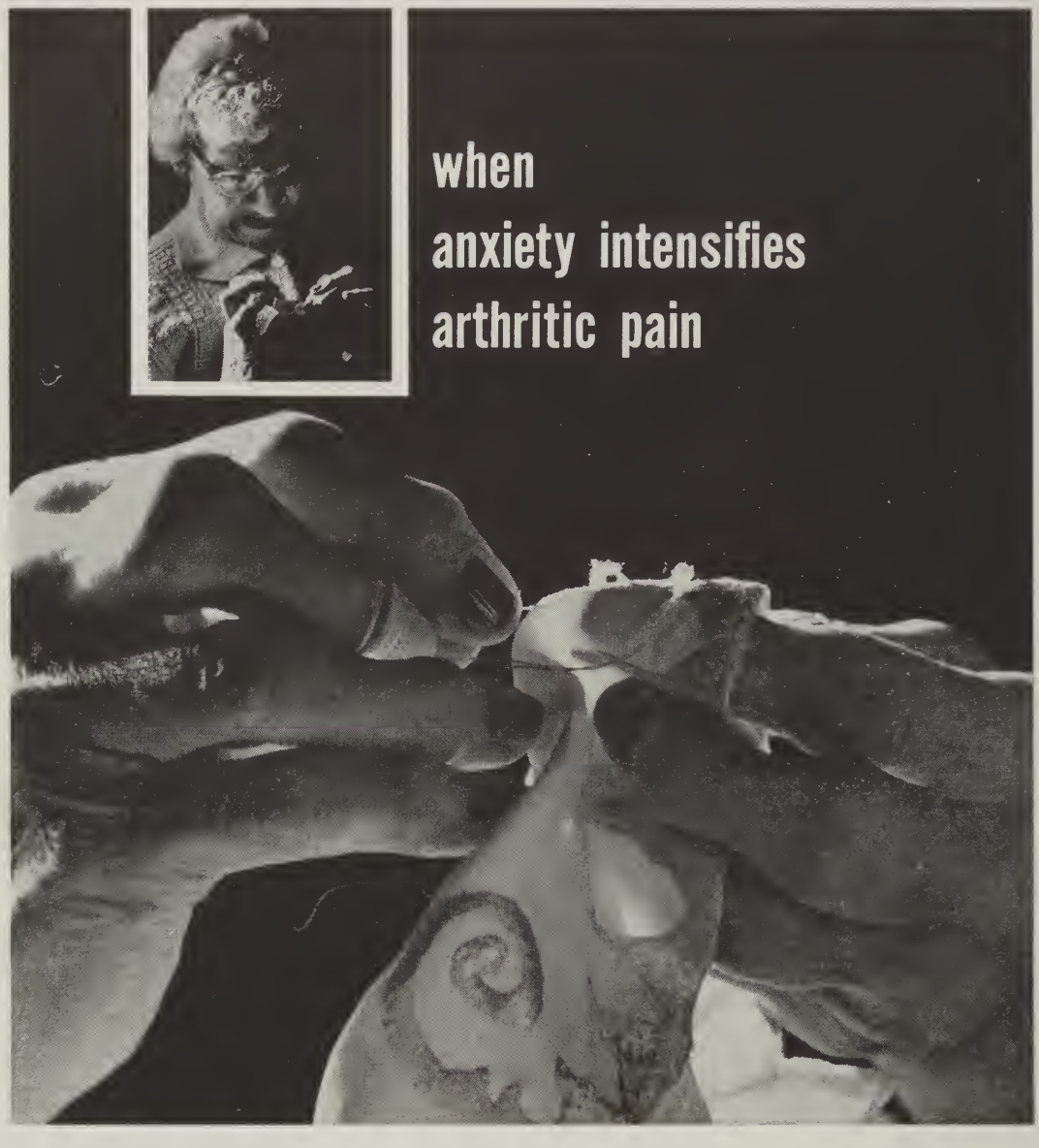
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The JOURNAL of the
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ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 58 MARCH, 1960 NO. 3

Progress In Cancer Research

JOHN R. HELLER, M.D.*

Bethesda, Md.

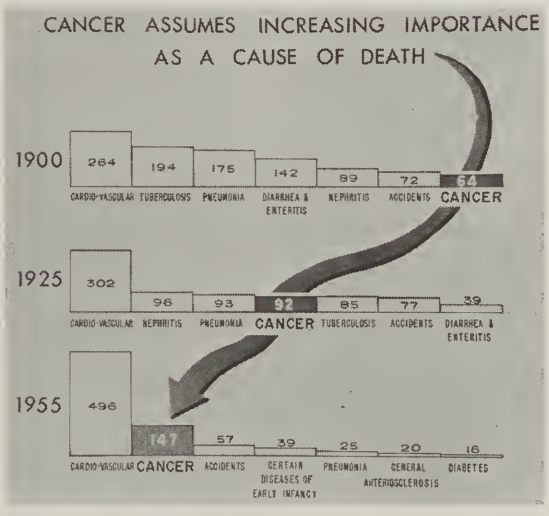
Research in virology, chemotherapy, cytology and epidemiology has produced achievements that may provide means of effectively controlling malignant disease

I intend to discuss progress in cancer research from a broad vantage point and—if you will—to separate the trees from the forest.

An appropriate place to begin is to look at the magnitude of cancer. Cancer is the second most frequent cause of death in the United States; only diseases of the cardiovascular system cause more fatalities.

An estimated 450,000 new cases are diagnosed every year, deaths total more than a quarter of a million annually, and there are 700,000 persons under treatment for malignant disease. If these trends continue at their present rates, 40,000,000 persons now living will develop cancer in their lifetimes, and 26,000,000 of them will die of it.

Statistics cannot begin to describe the impact



of cancer on the individual or his family, but rather than dwell on them, I should like to turn to a discussion of some of the paths research is taking in the effort to produce ways of controlling, and hopefully eradicating, cancer as a threat to the well being of men, women and children everywhere.

There are four areas of cancer research to which I should like to devote particular attention: virology, chemotherapy, cytology and epidemiology. Significant progress has been reported from each of these fields within recent years and I believe that any, perhaps all, of these achievements may profoundly influence our ability to control human cancer.

* *Director, National Cancer Institute, National Institutes of Health, Public Health Service, Department of Health, Education and Welfare, Bethesda, Md. For presentation to the Kentucky State Medical Association at its Annual Meeting, Louisville, Ky., September 24, 1959.*

Viruses and Cancer

For more than 50 years evidence has been accumulating that viruses cause cancer in animals; in fact, almost since the very beginning of modern cancer research has this story been unfolding. Some amazing information about animal tumor viruses and the cell components with which they appear to be intimately associated has been brought to light by this line of research. As a result, cancer investigators are intensifying their efforts in the study of the possible viral etiology of human cancer.

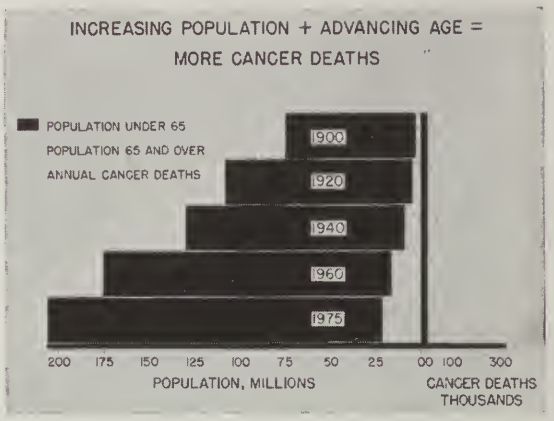
The accompanying table shows early developments in virus-cancer research. Borrel, in 1903, made the suggestion that viruses cause cancer,

VIRUS—CANCER RESEARCH, 1903-1936

1903—BORREL, first suggested viruses cause cancer
1908—ELLERMAN and BANG, discovered animal virus tumors
1911—ROUS, discovered animal virus tumors
1933—SHOPE, solid tumor in rabbits
1934—LUCKE, kidney cancer in frogs
1936—BITTNER, breast cancer in mice

but the significance of the results was not immediately recognized and research in this area proceeded rather slowly. In 1908, Ellerman and Bang established the first direct causal relationship between cancer and a virus in their work on the transmission of fowl leukemia by cell-free preparations. Rous, in 1911, discovered that a sarcoma that had appeared spontaneously in a Plymouth Rock chicken could be passed from chicken to chicken by means of cell-free filtrates. Almost a quarter of a century elapsed before the next major advances were recorded: the discovery of the Shope papilloma virus in 1933, the Lucké virus of the leopard frog in 1934, and the Bittner mammary tumor virus of mice in 1936.[1]

Intensified research on cancer viruses might be considered to date from Gross' observations in 1951 that the inoculation of newborn mice with cell-free extracts obtained from a mouse leukemia resulted in leukemia within one or two years. Stewart and Eddy of the National Institutes of Health, working with some of Gross' material, observed the appearance not of leukemia but of parotid-gland tumors.[2] When cell suspensions of this parotid tumor were carried in tissue culture,



the tumor-producing ability of the material assumed an explosive character. Injection of the supernatant fluid from the cultures into newborn mice resulted in the development of 23 different types of primary tumors, including parotid gland tumors, and tumors of the thymus, adrenal glands and mammary glands.

Stewart and Eddy showed subsequently that this agent, now known as the polyoma virus, has the additional remarkable capacity to cross strain and species barriers. It induced sarcomas and vascular tumors in hamsters, and renal sarcomas and subcutaneous tumors in rats.[3, 4]

VIRUS—CANCER RESEARCH, 1951-1959

1951—GROSS, leukemia in mice
1956—STEWART and EDDY, multiple tumors in mice, rats and hamsters
1957—FRIEND, leukemia in mice
1957—FRIEND, immunized mice against leukemia
1957—BURMESTER, immunized chickens against visceral lymphomatosis
1957—SCHWARTZ, enhanced mouse leukemia by injection of human leukemia tissue
1957—DMOCHOWSKI, observed virus particles in human leukemia tissue
1958—STEWART and EDDY, immunized hamsters against polyoma virus
1959—MOLONEY, leukemia in mice

It is now believed that Gross' material contained two viruses, the leukemia virus and the parotid-gland tumor virus, and that the activity of the latter was increased by passage through tissue culture.

As recently as a few months ago, Moloney at the National Cancer Institute isolated from sarcoma 37, one of the transplantable mouse tumors, a virus that produces lymphocytic leukemia in mice.[5] Activity of this virus has been so increased that it now causes leukemia within 10 weeks in all mice injected

on the first day of life. This virus produces the disease in several different strains, is active in adults as well as newborns, and produces a leukemia which is indistinguishable from the spontaneous type of the disease.

As research on animal tumor viruses progresses, attempts are made to develop vaccines that will protect susceptible animals against the tumors. Stewart and Eddy successfully inhibited the development of tumors induced in hamsters by the polyoma virus.[6] This was accomplished by injecting young hamsters with a neutral mixture of polyoma virus and antibody-containing rabbit serum. Hamsters were injected with the virus antibody mixture when two days old and again six days later. On challenge with the active virus alone two weeks after the second immunizing injection, 97 per cent of the hamsters failed to develop tumors and survived six months until the experiment was terminated. Sixty-seven per cent of the unimmunized control litter mates that received the same virus challenge died with tumors within five months.

The National Cancer Institute has initiated a long-range program of research in the areas of viruses and human cancer. Within the past few months, 26 new research grants valued at $1,250,000 have been awarded to aid virus studies. Support for some of the grantees has been recommended for periods up to 10 years and could total more than $10,000,000 to be financed out of the Institute's annual appropriations. Among the leading virologists receiving grants is Charles Oberling, the eminent French scientist who long has championed research on virus-cancer relationships. Other virus-research grantees include Albert Sabin, one of the leaders in poliomyelitis research, and Joseph Beard, a pioneer investigator in tumor-virus studies.

Cancer Chemotherapy

I should like now to turn to a discussion of chemotherapy research, one of the most active and promising paths in the scientific quest for the control of cancer. Many scientists believe that the greatest hope for effective treatment of disseminated cancer is in the field of drug therapy.

Within the last 15 years, some 20 drugs have been developed that temporarily benefit patients with various forms of malignant disease and the search for better drugs and more effective ways of using existing drugs has produced some of the most dramatic results yet achieved in cancer research. Research in this area is proceeding along several lines, such as, for example, development of new classes of drugs, alterations of the structure of existing drugs known to possess anticancer ability, and improvement in techniques of drug administration.

Antimetabolites

One of the newly-developed drugs is 5-fluorouracil, a member of a new class of antimetabolites known as fluorinated pyrimidines. Antimetabolites are believed to accomplish their anticancer action by interfering with the biosynthesis of a vital cell component, nucleic acid. Administration of 5-FU produced objective remissions in patients with cancer of the breast, colon and rectum, but not, however, without the development of toxicity.[7] Attempts to reduce the toxicity of 5-FU led to the synthesis of 5-fluoro-2′-deoxyuridine, or 5-FUDR, and patients could tolerate twice as much 5-FUDR before signs of toxicity appeared.[8] Since regressions have been accompanied by toxic manifestations in both 5-FU and 5-FUDR, investigators are studying other derivatives in the hope of producing a high degree of therapeutic activity while minimizing toxicity.

An example of structural alteration of a drug already in clinical use is illustrated by 3′, 5-dichloroamethopterin and 3′-bromo-5′-chloroamethopterin which were derived from the well-known antileukemic drug, methotrexate. Goldin and his colleagues at the National Cancer Institute found that methotrexate was the most effective of a group of 38 drugs in prolonging the survival of mice with far advanced leukemia. Later, a number of derivatives of methotrexate were studied by a similar screening procedure, and two of the drugs — 3′, 5-dichloroamethpoterin and 3′-bromo-5′-chloroamethopterin—were three to four times as effective as methotrexate in extending the survival of leukemic mice. Some of the mice were alive and presumably "cured" at the end

of six months.[9] There is, of course, no guarantee that similar results will be obtained in clinical trials now in progress, but we are at least provided with a demonstration in animals that one kind of systemic cancer can be controlled with drugs.

An example of the efforts to improve the steroid drugs has been given in a report by Blackburn and his associates at the Mayo Clinic in the treatment of a small group of postmenopausal women with metastatic breast cancer with 2-alpha-methyl-dihydrotestosterone propionate, a derivative of testosterone propionate developed in Mexico.[10] Twelve of 27 patients given the new drug experienced temporary regression of metastatic lesions as compared with 3 of 21 patients given testosterone propionate. The new drug, in addition to exerting an inhibitory effect at least equal to, and possibly superior to, testosterone is significantly less androgenic than the parent drug. Further clinical experience will of course be necessary before definitive evaluation can be made.

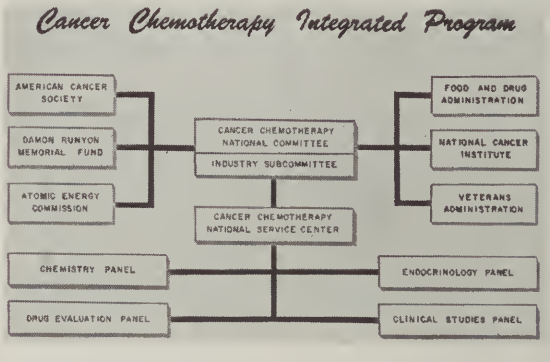
Exciting New Advance

In the area of improved administration of drugs, an exciting new advance has been shown in the treatment of a rare but highly malignant tumor, choriocarcinoma, by means of a specially designed regimen for administering methotrexate.[11] Some 40 women patients have been treated at the National Cancer Institute during a period of about three years. Most of them were gravely ill on admission, with widespread involvement of the pelvic region and metastases to the lungs. A few also presented evidence of central nervous system involvement.

The drug was given intramuscularly or by continuous intravenous drip in a large dose administered in equal portions over a period of five days. The course was repeated at about two-week intervals for two months or more. Response to treatment was measured by the amount of the hormone, chorionic gonadotropin, produced by the tumor and excreted in the urine. Other responses observed were chest X-ray changes and improvement in pelvic and cerebral involvement.

Complete remissions with no hormonal, radiological or physical evidence of recurrence for periods ranging from several months to three years have been observed in about one-third of the patients. One patient has been free of the disease for 36 months, without any signs of the malignancy or of increased gonadotropin titer. The success in prolonging lives of even this small group of patients is extremely encouraging, when one considers that this tumor usually kills a patient in less than one year.

A new drug that appears to warrant intensive clinical study is cytoxan, a German-made compound related to nitrogen mustard. Reports from Europe of impressive clinical experience with this drug led to its introduction into the national chemotherapy screening program. The results obtained in the screening have corroborated the information reported from Europe.



Chemotherapy research activities have been vastly accelerated in the past several years as a result of the organization of the national chemotherapy program of cooperative research established by the United States Government to discover and evaluate compounds for the treatment of cancer.

Under this program, independent research institutions, colleges and universities, and private industries, as well as the Federal government, have pooled their resources and talents in a national cooperative effort. Candidate drugs are screened against mouse tumors at the rate of 40,000 a year and the small fraction that show promise are studied further and ultimately evaluated in the clinic. At present, about 100 drugs are being investigated in more than 150 hospitals across the country.

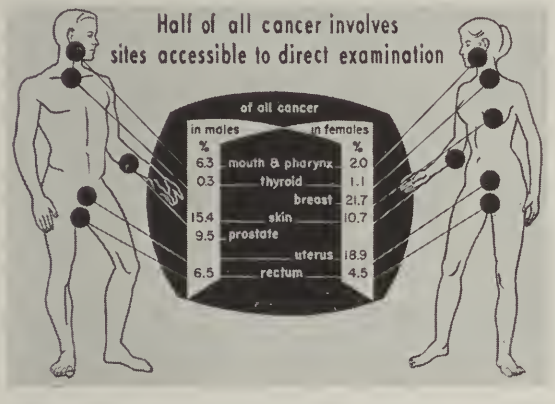
We believe that chemotherapy will eventu-

ally stand with surgery and radiation — and perhaps supersede them — as a means for curing malignant disease in man. Experience in the past decade or so would seem to indicate that medical science will succeed in developing a number of lastingly effective anticancer drugs and in learning how to use them to the best possible advantage.

Cytology and Diagnostics

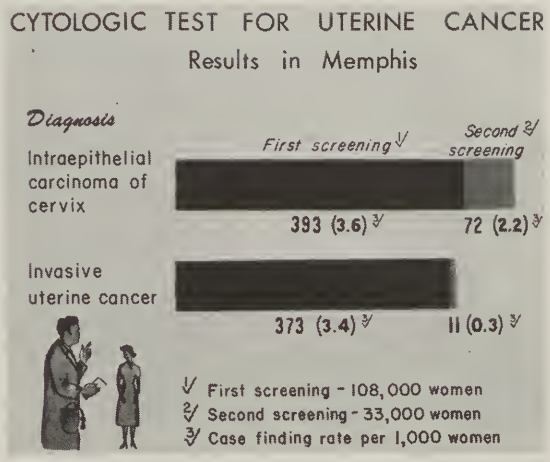
In the present knowledge of malignant disease, it is essential that cancer be diagnosed at the earliest possible moment, for delay almost invariably carries with it a lessened opportunity for effective treatment.

Fully half of all cancers involve sites that are accessible to direct examination during a routine checkup. Encouraging as this fact is, however, it must be remembered that many tumors so detected will already have progressed beyond the reach of curative therapy. What we need to improve this picture is either a



battery of tests that will detect cancer in its earliest stages or a general test for malignancy. Research to improve cancer diagnosis is pursuing both of these objectives.

Certainly the cytologic test for uterine cancer stands as one of the most important achievements in cancer diagnosis and detection. The test was developed by Papanicolaou and Traut and involves the microscopic examination of vaginal fluid.[12] Scientists of the National Cancer Institute in cooperation with the University of Tennessee and other local medical and health groups studied the cytologic test as a case-finding procedure in the adult female population of metropolitan Memphis.[13]



Among 108,000 women examined in the first round of screening, about 800 cases of cancer were detected and later diagnosed microscopically. Half of these cases were of intraepithelial carcinoma, which has a high cure rate. Ninety per cent of these cases were unsuspected. The remaining 400 cancers were invasive to varying degrees and, of these, 30 per cent were unsuspected.

About a year later, 33,000 of the original 108,000 received a second cytological test. In this group, another 83 cases of malignancy were discovered, of which 72 were intraepithelial and 11 invasive. In terms of rates per thousand, there was a slight decrease for intraepithelial cancer, from 3.6 detected on the first screening to 2.2 on the second. For invasive cancer, the drop was far more significant, from 3.4 on the first screening to 0.3 on the second. Thus the rate for invasive cancer was on the second examination only one tenth that on the first. Further analysis of the Memphis data showed moreover that invasive cancer may remain asymptomatic for two or three years, although the disease can be detected by cytologic examination during this symptom-free period.

Scientists of the National Cancer Institute and other laboratories are studying the application of the cytologic test to the detection of cancer in other sites, such as the lung, large bowel, urinary bladder, prostate gland, and stomach.[14]

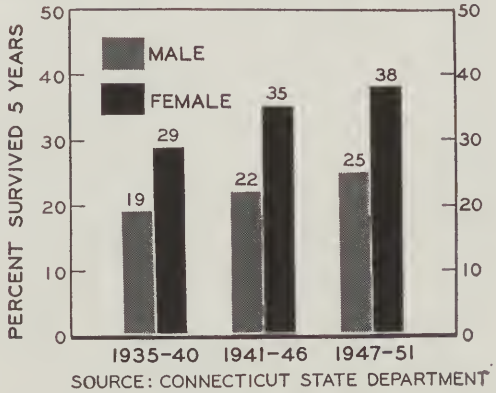
Epidemiology

If we are to achieve our objective of reducing the impact of malignant disease, we must

have some knowledge of the extent of cancer in populations. Through epidemiological research, scientists are able to recognize trends in cancer incidence and mortality, variations by age, race, sex or occupation and observe progress in controlling cancer by applying the products of research.

There have been two large-scale cancer epidemiology studies in the United States whose results might be considered applicable to the country at large. These are "Morbidity from Cancer in the United States" and "Cancer in Connecticut—1935-1951." In the first of these

SURVIVAL EXPERIENCE IN CONNECTICUT



SOURCE: CONNECTICUT STATE DEPARTMENT OF HEALTH.

studies, cancer incidence data were collected twice, in 1937-1939 and 1947-1948, in ten metropolitan areas selected to represent different geographic regions.[15] In the Connecticut study, data were gathered over three five-year periods on all known cancer cases in the State.[16] Incidence, diagnosis, treatment and survival data were reported for about 75,000 cancer patients. Both of these studies have proved to be of inestimable value in appraising the magnitude of the cancer problem.

Analysis of the Connecticut data reveals a changing pattern of cancer survival. The five-year survival rates for males increased from 19 per cent in the period 1935-1940 to 25 per cent in 1947-1951. The corresponding increase for females was from 29 to 38 per cent. Among the sites for which the greatest increase in survival was observed were large intestine in both men and women, rectum in men, and uterus in women. The investigators who compiled and analyzed these data concluded that the increase in survival of cancer patients apparently resulted more from improvement in treatment than earlier case finding. However, the most heartening and important fact learned from this study was that in 20 years the proportion of cancer patients surviving five years after diagnosis rose from one in four to one in three.

The sharp rise in the incidence of lung cancer has spurred intensive research into the etiology of this form of cancer. Statistical research, supported by laboratory evidence, indicates that excessive cigarette smoking is one of the causative factors in lung cancer.[17] One investigator has reported the results of a study leading him to suggest that tobacco smoke and air pollutants may act in combination to produce lung cancer, thus accounting for the higher incidence among urban, compared with rural, residents.[18] By way of contrast, the incidence of stomach cancer has been declining steadily in the United States in the past few decades.[19] The carcinogenic effect of X-rays, radioactive substances and sunlight has been revealed by laboratory and epidemiological studies. The possible extent to which fallout from atomic explosions may pose a cancer hazard needs to be clarified by systematic research.

It is recognized that both known and unknown factors may contribute to the causation of malignant disease. In order to obtain information on this subject, the National Cancer Institute has established at Hagerstown, Maryland, a long-term epidemiological study of the influence of environmental factors in the cancer attack rate This community was selected because the population is stable and complete medical records dating from the latter part of the 19th Century are available. Further, the geography of the area is sufficiently varied to provide a broad topographical spectrum.

The Pattern of Cancer Research

Progress in cancer research in the United States has been the result of the simultaneous activity of many independent and, at the same time, interdependent disciplines. The research is financed by cooperative funds, coordinated by cooperative organizations, and performed by cooperating skills. This cooperative effort owes its presence to the nature of cancer, which, after a half-century of investigation, remains an enigma.

About $130 million is being invested annually in cancer research, of which 90 per cent is spent by the agencies of the Federal Government, such as the National Cancer Institute, Atomic Energy Commission, and Veterans Administration. Agencies such as the American Cancer Society, the Damon Runyon Memorial Fund, the Tobacco Industry Reseach Committee and the Sloan-Kettering Institute for Cancer Research account for the remainder.

An example of cooperating organizations is found in the reseach grants program of the National Cancer Institute, in which the work of many investigators throughout the United States and abroad is supported in some 1,500 grants on all aspects of cancer research — diagnosis, cause, treatment and characteristics. The American Cancer Society, largest voluntary organization of its kind, also supports similar research through awarding of over 500 grants.

Since World War II, there has been an ever increasing number of new and refined techniques available to the cancer investigator. Radioisotopes, the electron microscope, tissue culture and inbred strains of mice are but a few. Established scientific paths, such as biology, chemistry and physiology, are dividing and merging into new highways of research: virus oncology, radiobiology and chemotherapeutics. If this trend continues, perhaps oncology will one day become a scientific discipline in its own right.

Conclusion

Progress in medical science is sometimes made with agonizing slowness, as you well know. However, when we analyze our findings in virology, chemotherapy, cytology and diagnostics, and in epidemiology, we are encouraged by the achievements attained thus far and excited by the anticipation of results yet to be realized.

If we can prove that viruses are responsible for human cancer, then we may be able to prevent some malignancies by developing vaccines in much the same way that research has produced a poliomyelitis vaccine in the past few years.

Our progress in chemotherapy has been rewarding, resulting in some "cures" in laboratory animals and some comparatively long remissions in patients. We must now find really effective drugs that will attack cancer cells wherever they occur in the body.

Advances in cytology have forged ahead so that virtual eradication of one type of cancer — cancer of the uterus — appears to be a possibility. Our efforts must now be directed toward early detection of cancer of other sites by cytologic or other tests.

Increased efforts must be made to identify cancer-causing or cancer-potentiating agents in the environment in which we live and work, to exploit new techniques and procedures, and to elucidate some of the mechanisms of normal and cancerous growth.

The resources with which to solve the problem of cancer are within our grasp. Aided by them, research scientists are amassing the knowledge that will make possible the eradication of malignant disease as a threat to mankind. This is our goal, and I confidently believe that medical science is making impressive progress toward its achievement.

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Forensic Pathology

The Function and Responsibility of the Coroner's Office

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Performance of the medicolegal autopsy is a serious and difficult task with innumerable traps for the untrained pathologist. Upon it may depend the life of another human being

ONE of the most important and yet too often neglected elective officers of the county is the coroner. The major function of the coroner is to initiate the investigation of a death. Usually the type of death is clearly defined by the state legislature. In Kentucky, a coroner's case has been defined as "the body of any person slain, drowned or otherwise suddenly killed, or whose death occurred from unnatural cause."

Scientifically, the death of any person is an intriguing problem of diagnosis and a fascinating study of disease processes. Legally, there are problems of insurance, settlement of estates and inheritance, and, finally, the detection of death by criminal means. Any person whose death occurs suddenly or unexpectedly or is in any way related to trauma should be subjected to a post-mortem examination.

An order from the coroner authorizing the performance of the autopsy by a trained pathologist constitutes one major aspect of the practice of the special field of medicine which is termed "forensic pathology." The scope and definition of forensic pathology as related to the function of the coroner are the fundamental purposes of this discussion.

Definition

Forensic pathology may be defined as the application of the knowledge of pathology to the controversial issues that arise when a human being meets death as the result of or during the commission of a criminal act. The ability to perform a necropsy and ascertain the cause, mode and manner of death resulting from unlawful act is possessed only by the pathologist who has had special training. The forensic pathologist has studied deaths resulting from blunt injury of either human or mechanical origin, from penetrating and perforating wounds inflicted either by firearms, bladed weapons or other instruments, from chemical injury, i.e., death from poisons, from thermal injuries, or from any combination of such mechanisms.

The primary function of the medicolegal pathologist is to investigate the death of any person who dies as the result of criminal or violent means, or by casualty, or suicide, or suddenly when in apparent health, or in any suspicious or unusual manner. This definition encompasses deaths attributable to blunt injury, gunshot wounds, stab wounds, drowning, poisoning, electrocution and severe burns.

It is of basic importance that the coroner, as the responsible administrating officer, recognize his duties and responsibilities. He must know the requisites of the medicolegal autopsy before he can intelligently select the pathologist as his representative. His knowledge of the re-

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quirements of the police and prosecutor in their investigations of crimes and the subsequent indictment and trial of criminal suspects clearly indicates that the post-mortem examination must provide more data than merely the cause of death.

If the coroner fails to appoint, either temporarily or permanently, a forensic pathologist to his staff for the performance of the forensic autopsy, then he has failed his primary responsibility—for the medicolegal autopsy cannot be delegated to anyone other than the forensic pathologist. Only a physician has the skill, knowledge and training necessary to evaluate disease as related to death. Only a pathologist has the necessary knowledge of anatomical disease and physical injury which constitute the basis of forensic pathology. All physicians have a moral obligation to render service to the community. Such service is exemplified by the willingness to serve either as coroner or forensic pathologist.

Reason for the Specialist

The essential element in the armamentarium of the forensic pathologist is his ability to obtain the necessary information from the post-mortem examination which will enable him and the responsible authorities to decide whether a death is the result of homicidal, suicidal, accidental or natural causes. Whenever the coroner does not investigate deaths using the services of the forensic pathologist, there is always the probability of a person committing murder and remaining undetected or of an innocent person being charged with a crime that has not been committed.

The fundamental reason for the existence of the office of coroner is to investigate the occurrence of a death. If the autopsy is performed by someone other than the forensic pathologist, the entire procedure and expenditure may prove to be a total loss. The medicolegal autopsy must be made, categorically, by a specialist who recognizes the requirements of such an examination. The purpose of the examination is not merely to determine the cause of death but, in addition, to provide a volume of related, useful, factual data for the police and prosecutor. The failure to obtain, describe, record, identify and preserve evidence can result only in a miscarriage of justice.

The Medicolegal Autopsy

The scope of the medicolegal autopsy is so great as to almost defy simple definition. In order to consider such a scientific undertaking properly, let us look at the examination in its total content.

The medicolegal autopsy begins literally with the finding of a dead body. Thus, we must consider examination of the body in toto in relation to its surroundings. It may be essential, therefore, for the pathologist to examine the body at the scene before any change has been introduced. Such an examination gives information as to the position of the body in relation to its surroundings, no matter whether this is inside a building or in a desolate field. These relationships can provide knowledge that would be missed completely by an investigating officer, but that would be a key to opening the door of understanding for the forensic pathologist.

The pattern of blood stains on a wall, floor, rug or other object is seen only as blood by the investigator, but to the forensic pathologist the stains represent sources of information. Degree and extent of injury providing the source of the blood must be considered. Evidence of struggle and type of weapon may be suggested. Condition of the blood can indicate the time of injury. All of these constitute points of information to be evaluated much later in order to arrive at definitive conclusions and opinions concerning pertinent matters.

Moving the Body

Once the body has been removed from the scene, valuable information is lost, for the very position of the body, arrangement of the clothing or objects on or about the body may reveal whether or not the body was moved and placed in the position in which it is found. The objects, while trivial in appearance, may be valuable evidence that otherwise would be overlooked and perhaps ultimately lost.

Experience in the field has shown that mistakes are so commonly made that it is essential for an experienced observer to record the pertinent facts. For example, in the case of a homi-

cide of an infant, a washcloth that had been stuffed into the mouth was removed and lost by an investigator. As a result, when examined by a pathologist, the body of the infant showed no evidence of the manner of death. In another instance, the untying of a noose about the neck of a victim and subsequent loss of the ligature prevented examination as to the type of knot and signs of abrasion on the cord. Examination of this sort could have eliminated conclusively the theory of homicide. It is a didactic rule, in the investigation of a homicide, that the assailant leaves something pertaining to his identity at the scene of the crime and also carries away with him something that will relate his presence to the scene.

Examination of Clothing

No medicolegal autopsy can be deemed complete without an examination of the clothing. These items may bear the telltale evidence to identify the victim and/or the assailant. One of the most important facts to remember is that the victim, when alive, dressed himself in an orderly manner. The clothing can, and must, be removed carefully and preserved intact.

All too frenquently, clothing represents extremely important pieces of evidence used in a subsequent trial. It may be necessary to examine the clothing for blood stains, seminal stains, traces of powder residue from the firing of guns, traces of paint or grease from an automobile, or many other items dependent entirely upon the nature of the death. In some cases, the underarm portions of garments have provided enough residue or perspiration to enable the determination of the blood type of the victim; in others, the identification of the blood type of a suspect through the typing of seminal stains has proved to be invaluable evidence. Examination of the clothing visually and chemically may prove the point of entrance of a projectile and establish the fact that the gun was, or was not, fired in close proximity to the victim. Each of these points provides the framework for the final evaluation of the guilt or innocence of a suspect.

Many physicians and pathologists have the impression that examination of the clothing is a technical matter best left in the hands of the police investigator. Few of them realize that in cases of suicide, the victim will carefully remove or push aside the clothing before inflicting the fatal gunshot or stab wound; whereas, the criminal assailant in the attack upon the victim shoots or stabs through the clothing. Only with a careful examination by the pathologist can a specific correlation of the defects or tears in such garments be made as to the location, direction and pattern of injuries on the body of the victim. In some cases, a projectile may pass completely through the clothing and body of a person in such a manner that the entrance and exit wounds cannot be identified positively and only the tearing of the fibers in the cloth will clearly illustrate the differences between the points of entrance and exit.

In a number of cases of homicide, the identification of the victim has been established through proper examination and preservation of clothing. Such facts as size, manufacturer, type of material, individual style and color have played significant roles in investigation and identification. For these reasons, the important part that clothing may play in the solution of a crime must not be underestimated at the outset of a medicolegal autopsy.

Examination of Exterior of Body

The examination of the exterior of the body is probably the most distinguishing feature that differentiates the medicolegal autopsy from the hospital autopsy. There must be an extremely detailed, written description of the body surface to preserve forever the minutiae of the injuries. The size, shape and specific location are important. The character of the surface of the skin bearing abrasions furnishes information as to the direction of the force.

The details of a stab wound will permit identification of various physical aspects of the knife involved, such as single or double sharp edge, square or rounded edge. An oval wound results from an ice pick, an unusual triangular wound from a pair of scissors. This information is obvious to the trained forensic pathologist but is a foreign, incomprehensible language to the novice. Painstaking examination of the head of a person with a heavy growth of hair may disclose the hidden gunshot or stab wound that has been fatal, but which has failed to

hemorrhage externally with any degree of significance.

The presence of numerous injuries upon the extensor surfaces of the hands and forearms is positive proof of a struggle between the victim and assailant, and such injuries are termed defensive wounds, suggestive of the manner in which they were sustained. In deaths induced by bladed weapons, the hands of the victim may be cut to ribbons by the many attempts to grab and hold the blade.

In examination of the extremities, the hands must always be given particular attention. Beneath the fingernails may be found fragments of skin and/or hair of the assailant or drops of blood, indicating injury to the attacker. Fracture of the fingernails, contusions of the fingers or knuckles and any other change from the normal becomes a part of the factual report. It does not matter whether such evidence favors the defense or the prosecution, but it is important so that the medicolegal autopsy may be complete. The interpretation and conclusions to be made from the findings become a matter of concern only at the end of the examination and later, when such data will serve to make an intelligible story from a mass of facts gathered by many different persons.

Impartial, Factual Report

It will be mentioned here only, for it is not pertinent to this discussion, that the medicolegal autopsy is an impartial, factual report by an unbiased trained pathologist. The data obtained are for the benefit of the police, prosecutor and the defendant. The forensic pathologist is not a detective in the police sense, nor is he judge or jury; he must rather be a skillful scientific observer whose knowledge and experience portray his unprejudiced recording of facts. These facts must be detailed, concise and clear so that any other expert would, of necessity, arrive at the same interpretation and conclusion.

It is the special training of the forensic pathologist and his previous experience which permit the evaluation of the changes occurring in the human body after death. A series of changes takes place after death: post-mortem flaccidity, rigor mortis, livor mortis, putrefaction and loss of heat. Under certain circumstances, these changes occur in a more or less orderly fashion, but are specifically influenced by disturbance of the body, environmental conditions such as rain, heat and cold, location, wind currents and scavenger insects. The trained examiner must investigate these conditions as a matter of routine; otherwise, they are not recorded and may never be available for evaluation. Measurement of heat loss from the body can be recorded by taking the temperature of the liver, brain or rectum.[1] Only by consideration of the total changes occurring in the body after death can the time of death be reasonably estimated.

The examination of the exterior of the body, then, is another step in the orderly conduct of the medicolegal autopsy.

Where Violence Is Involved

In the examination of the body of a person who has met death as the result of violence, the injuries are noted and described in detail, being located descriptively in relation to readily observed, fixed and unchanging features of the exterior of the body. If this is done, any person, medically or legally trained, or a lay person will easily understand the precise location of the injuries. It must be remembered constantly that in general the individuals who will subsequently make use of the autopsy protocol will not have medical training, and these are the persons who must ultimately rely upon the accuracy and clarity of the pathologist's descriptive efforts. If the report is not intelligible to the prosecutor, police or defense attorney, then the value of the pathologist is lost. It is not sufficient that the appearance of the injuries upon the body of the deceased seem to indicate the cause of death. It must rather be shown conclusively that the injuries and these alone were the direct cause of death.

The most striking example of this point can be illustrated by the following: The body of a woman found dead on the shore of a lake had the unmistakable evidence of a ligature strangulation. There was a patterned abrasion on the front and both sides of the neck. In relation to this linear abrasion, there were a

[1] Lyle, Herbert P., Stemmer, Klaus L. and Cleveland, Frank P.: Determination of The Time of Death. A Consideration of Post-Mortem Physical Changes. J. of Forensic Sci. 4:167-74, April 1959.

series of small crescentic and straight linear abrasions above and below the ligature mark. At this point everyone was satisfied that death had resulted from strangulation by ligature. However, completion of the autopsy disclosed that in reality the victim had died as a result of drowning. This was confirmed by the suspect who admitted the strangulation until the deceased was unconscious. Then the body was dragged into the water and held beneath the water until death ensued, after which the body was removed from the water and left to be found lying on the shore.

The failure to make a complete post-mortem examination in the investigation of cases under the jurisdiction of the coroner (or medical examiner) can result in a possible miscarriage of justice. It may be said that, as a basic rule, murder will go undetected and innocent persons will be unjustly accused of crime only when there is no post-mortem examination at all, or when such examination is incomplete.

Use of Photography

One of the greatest aids to the forensic pathologist is the camera. With a little knowledge, practice and willingness, and with the use of good equipment, any pathologist can become a competent photographer for medicolegal purposes. In their role as teachers, pathologists generally have an insatiable desire to preserve their interesting anatomical specimens for the edification of their students and colleagues. Photography is their natural hobby and talent.

Photographs are valuable for the following reasons: The identity of the body may be established; the build and development of the body is shown; the injuries may be clearly evident as to characteristics and location. A good photograph can be viewed and understood by practically everyone and, at the proper time, may replace a wordy discussion. However, one should never consider a photograph as a substitute for a comprehensive, clear and concise description of the body and injuries in the medicolegal autopsy. The photograph is a supplement to an intelligent examination.

Various special types of photographic techniques may have great value in certain instances. Infrared photographs may be used to bring out the details of a faded tattoo on a decomposed body.

Today, photographs are the accepted and literally required supplement in the forensic autopsy. Perhaps one of the greatest applications of photography in forensic pathology is its use in the training of medical students, residents, coroners, police officers and other pathologists. Students, residents and pathologists must be taught in this manner so as to interest them in the nature and importance of this work. Since there is a deficiency of competent men in the field, every effort must be expended to provide knowledge and to recruit others to aid in the field.

To coroners, police officers and prosecutors, such teaching serves to illustrate the capabilities of the forensic pathologist and illustrates the value of having the work performed by competent persons. Once these persons are convinced of the value, a demand is created to raise the standards of the work performed in their jurisdiction. Such demand merely places the responsibility on the proper individuals, the coroners, whose function is to investigate deaths resulting from criminal violence.

The use of photographs in the trial of a person for murder is obvious, for they clearly show the jury that a person — a human being — has met death violently by the hands of another.

Examination of Interior of Body

The medicolegal autopsy is a complete examination of the human body and must include the head, neck, thorax, abdomen, vertebrae, extremities, internal organs, external genitalia and body orifices. Examination of the interior of the body notes the relationship of the surface injury to the injury of the underlying tissues. In the case of penetrating injuries, the course and direction of the wound, the specific organs involved, the depth of penetration, and the results of such penetration are recorded.

In head injuries, the significance of contracoup injury must be recognized. The pattern of fractures in the skull may be a valuable clue indicating that the trauma may have resulted from a fall rather than a blow to the head. Subarachnoid hemorrhage from rupture

of an aneurysm of an artery must be recognized as spontaneous and non-traumatic, whereas subdural and epidural hemorrhage are almost invariably traumatic in origin. However, the unusual causes of subdural hemorrhage, such as malignancy and intracerebral hemorrhage, should be considered before prematurely recording the cause as traumatic.

The neck organs and the cervical vertebrae are infrequently examined in the routine post-mortem examination. These two sites must always be dissected in the medicolegal autopsy. Injury to the cervical spinal cord may be instantly fatal and may leave no external evidence of the trauma. In addition, such injury would be immediately incapacitating. This information could have unknown value and be of great assistance, should there be evidence of change in the position of the body, or allegations relating to the actions of the deceased.

Detailed examination of the internal organs of the neck may be the only evidence of manual strangulation. In such cases there may be hemorrhage into the musculature, fracture of the thyroid, or cricoid cartilages, or fracture of the hyoid bone. At times, persons who die suddenly or in a suspicious manner are found to have expired as the result of mechanical obstruction of the larynx by aspiration of foreign material. Only by dissection of neck organs can these deaths be clarified.

Gunshot Wounds

Contact gunshot wounds of the chest or abdomen may have the characteristic appearance externally of wounds that have been inflicted by a distant wound. Only upon dissection of the soft tissues along the course of the projectile tract can one find the traces of powder and smoke residue, thus indicating the true character of the wound. Either type could be the result of a homicidal act; however, the information can confirm or refute allegations by a suspect.

Blunt trauma of the abdomen may inflict fatal damage to the internal organs without external signs of injury. Each specific example derived from actual experience serves only to emphasize the importance of the complete post-mortem examination in medicolegal cases.

Special Examinations

The forensic pathologist must have a constant awareness of the need for special examinations and be prepared to undertake them. In situations where the cause of death cannot be ascertained by the gross anatomical changes, a suspicion of poisoning arises. The obtaining and preservation of uncontaminated samples of each organ and body fluids in sufficient quantity is essential. These specimens must be placed in chemically clean containers, properly identified and maintained in complete control of the pathologist in order to meet the legal requirements of evidence. In homicide or suspected homicide, samples of blood should be retained as a matter of routine, in order to determine blood type, alcohol content, and any other test that might immediately or subsequently be required. Pubic hair and scalp hair should be identified and retained for possible future use when there is a possibility of future need.

Two Cases Cited

Such routine and thoughtful preparation were invaluable in two cases. One was an automobile fatality in which the hair from the head of the child was compared with hair obtained from the wheel of the suspected vehicle. The second was an instance of rape in which hair on the clothing of the suspect was compared with the hair of the victim.

The routine performance of an analysis for ethyl alcohol in the blood of persons dying of violence often provides an explanation for the circumstances. Frequently, traffic fatalities of pedestrians are directly associated with the intoxication of the victim. In addition, the evaluation of quantities of such data shows a correlation between alcoholism and traffic accidents, and between alcoholism and homicide.

The application of the x-ray to forensic pathology has long been recognized but, as a matter of fact, it is not yet readily available. When bodies are putrefied or mummified, or are extensively destroyed by fire, x-ray studies become an absolute necessity. The x-ray will show fractures, the presence of foreign bodies and bony changes. The fractures are evidence of the violence of the injury. Foreign bodies, such as bullets or fragments of knife blades,

can be located more quickly and retained for ultimate comparison with related evidence. Bony changes may prove (and in the past have proved) to be the only positive manner of identification when all other methods have failed.

The retained items of clothing, bullets and various fluids and organs from the body must be properly identified immediately when obtained. They are maintained in the custody of the pathologist until duly turned over to an officer or chemist, either of whom may undertake further procedures before such items are eventually given into the charge of the prosecutor. Failure to keep the chain of possession intact may lead to failure and loss of the case during trial, for when the chain is broken and the security or identity cannot be established, the material is inadmissible as evidence to the court.

All of the representative portions of the organs and various other portions of the body that have been removed during the performance of the necropsy are prepared and examined microscopically. The slides of these tissue can confirm the various visual observations made during the gross autopsy, and are a necessary part of the complete medicolegal autopsy. Microscopic examination of material from the vagina is essential in cases of suspected rape in a homicide.

The final result of the medicolegal autopsy is to arrive at the diagnosis as to the cause of death. Diagnoses are in reality a statement of facts derived from the examination, upon which reasonable persons can reach the same conclusion as to the cause and manner of death. The interpretation of the medicolegal autopsy is the responsibility of the forensic pathologist.

Conclusion

The performance of the medicolegal autopsy is a serious and difficult task in which there are innumerable traps and pitfalls for the untrained pathologist. The autopsy is a detailed, all-inclusive, time-consuming examination that has both medical and legal objectives. The diagnoses and interpretations must be so accurately founded on clearly proven facts that they can withstand the most critical examination. The medicolegal autopsy as previously defined is the most important responsibility of the coroner, for thereon may depend the life of another human being.

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See Program On Page 351

Problems In The Recognition Of Acute Pericarditis

WILLIAM A. SODEMAN, B.S., M.D., SC.D.*

Philadelphia, Pa.

The disease is more frequent than usual clinical experience indicates. Its diagnosis is oftentimes missed because of the over-shadowing general clinical picture

THIS discussion will concern itself with two aspects of the problem of acute pericarditis. The first relates to the problem of general diagnosis, the second to the difficulties in the recognition and differentiation of the entity of acute idiopathic pericarditis, a common and important type.

Diagnosis of Acute Pericarditis

The diagnosis of acute pericarditis is, in general, not as clear cut and simple as the precise diagnostic criteria we utilize would lead one to believe. Herrmann[1] noted a two-fold difference between the necropsy and the clinical incidence of acute pericarditis. Therefore, even if one allows for terminal episodes, it is obvious that much pericarditis goes undiagnosed. Diagnostic criteria are often either not met or not recognized.

In a study of 240 patients previously reported,[2] we found that, among the multiplicity of factors concerned with adequate diagnosis, at least two were clearly brought out by the study. One concerned itself with acute pericarditis as a part of a generalized clinical picture. The other relates to the variable development and course of the diagnostic findings.

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Clinical Picture

Acute Pericarditis As a Part of a General Clinical Picture: Many patients, with such clinical states as uremia, rheumatic fever, generalized infections, and neoplasia, display a clinical picture with predominating symptoms and signs outside the area of the heart. In this group the findings of acute pericarditis are likely to develop at a time considerably postdating the onset and after the evolution of the primary clinical picture. The extrapericarditic symptoms may be very striking and draw attention to the patient and of the physician away from the heart. If the signs of pericarditis are not striking they may be missed unless repeated pointed examination is carried out. In addition, the patient's general state may dull his senses, as in uremia, so that new symptoms are not readily recognized.

In this group of patients, a disease such as uremia or generalized infection notorious for having pericarditis as part of the clinical picture should arouse suspicion of pericarditis and establish constant watch for symptoms and signs. Repeated sequential examination to establish involvement of the pericardium is necessary. Recognition of pericarditis in this group is often important clinically. For example, in neoplastic disease, it may be an indication of metastases and indicate inoperability. In lupus erythematosis it may be the indication of the involvement of another of the viscera and in this way be helpful in establishing the diagnosis.

Diagnostic Findings

Variable Development and Course of Diagnostic Findings: The usual diagnostic findings of acute pericarditis are (a) friction rub, (b)

characteristic electrocardiographic changes, (c) characteristic roentgenographic cardiac findings and (d) paracentesis of the pericardium. An analysis of clinical records[2] has indicated clearly that the development and course of diagnostic findings are sufficiently variable to account for many errors in diagnosis unless the disease is suspected and these findings are deliberately sought on repeated examination.

We have studied this variability in one acute type—acute idiopathic pericarditis—because this clinical entity has characteristics particularly useful for the study of the sequential development of diagnostic findings. The patients are usually young adults without preceding heart disease which would confuse the clinical cardiac findings or cause unrelated changes in the electrocardiagram. The patient is usually free of general or systemic disease, which would becloud the symptoms or interfere with the patient's alertness for new symptoms. The dramatic, sudden, painful onset usually marks the beginning of the clinical picture so that the time sequence of development of findings may be marked from a clear-cut onset. The patients are usually not extremely sick so that they may be handled well for roentgenographic studies, paracentesis, and other procedures. The friction rub is characteristically easily heard.

First Clinical Impressions

First clinical impressions of such patients, at primary examination, are often misleading. In a group of 40, only eight, or 20 per cent, were diagnosed on admission, an experience well documented by others.[3] Of 40, 16 were tentatively assigned a diagnosis of coronary occlusion, eleven pneumonia, two pulmonary embolism, two rheumatic fever, and one acute cholecystitis. The frequency of chest pain in acute idiopathic pericarditis, in contradistinction to its occurrence in other types, makes confusion with other painful syndromes more likely in this particular type of pericarditis. In 38 of these instances, observed by the same personnel, an analysis was made of the frequency with which the various diagnostic findings were elicited from the time of hospital admission through the active course of the disease. These are shown in Table I.

One can see that the incidence of findings diagnostic of pericarditis is far below the level at which any one of the findings alone could be depended upon uniformly. This may be accounted for in part by the lapse of 24 hours to five days from the onset of symptoms until hospital observations began. Indeed, in two instances friction was heard by the observers and disappeared before hospital admission, returning later in one patient.

Electrocardiographic changes which are characteristic and diagnostic of pericarditis may never develop, or if they do, may disappear or enter a non-specific stage, diagnostic of cardiac damage but not of pericarditis at the time a

TABLE I

Acute Nonspecific Pericarditis

INCIDENCE OF POSITIVE DIAGNOSTIC FINDINGS

Total Patients	38 (100.0%)
Friction Rub	26 (68.4%)
EKG Abnormal	35 (92.1%)
Diagnostic	25 (65.8%)
Nonspecific	10 (26.3%)
Roentgenographic Change-Cardiac Shadow	23 (60.5%)
Paracentesis	9 (23.7%)

tracing is taken. In the latter case, T-wave inversions associated with preceding precordial pain, may lead the observer to suspect or to arrive at a diagnosis of coronary disease, a common misdiagnosis in this group.

In general practice, when the physician is called early, or in military or school practice, when the patient turns himself in for sick call without delay, early or close observation would probably give a more favorable incidence of positive diagnostic findings. However, with the usual delays in practice or in observation of patients in institutions such as large city and county hospitals, the recognition of diagnostic findings is reduced. If sequential examination is started after friction has disappeared, or if it has not appeared at all, and after electrocardiographic changes, if any, have reached a non-diagnostic pattern, diagnosis may have to be made on the general course with support of the roentgenographic signs and if possible by paracentesis.

Cardiac enlargement occurred in our group (Table I) about as frequently as friction. This enlargement, especially when observed roent-

genographically, so that less evident changes can be followed, is important in diagnosis. As with the electrocardiographic changes, the roentgenogram of the heart is often abnormal but not diagnostic. In acute idiopathic pericarditis, the heart shadow may be enlarged or seem to enlarge under observation, only to regress again, a significant observation especially when no clinical evidence of myocarditis or of myocardial weakness appears and the change in size is unexplained.

The contour usually is not that of pericardial effusion. Indeed small effusions, under 300 ml, may not distort the cardiac contour at all. Large effusions producing the "pear-shaped" shadow and accompanied by changing contour with changing posture, although significant, are not common and a large flabby heart may produce similar changes. Clinical findings such as an apex beat well within the left border of cardiac dullness, or prolongation of the circulation time which is often present in the dilated heart but usually absent in pericarditis of the idiopathic or tuberculous type, may help in differentiation. Withdrawal of fluid, if air is replaced and proved to be in the pericardium, or if paracentesis is done with EKG monitoring while a lead connected to the needle indicates when the myocardium is touched as fluid is withdrawn, is of course diagnostic of effusion and if the fluid is an exudate, of pericarditis.

The obvious considerable variability in diagnostic findings is responsible for much in the way of diagnostic error. The diagnosis is easily missed unless the findings are deliberately sought. In many patients in whom non-specific findings alone are seen, emphasis must be placed on the total clinical picture, the progress, non-specific findings, such as cardiac enlargement and collateral findings, to develop a fund of data satisfactory for diagnosis.

Acute Idiopathic Pericarditis

Thus far in this duscussion we have considered problems in the general diagnosis of acute pericarditis. This second part of the report concerns itself with some of the specific diagnostic problems in acute idiopathic pericarditis. I shall pass over the details of the general symptoms and signs of acute idiopathic pericarditis. The propensity to occur in young adults a week or two after an upper respiratory infection, the painful onset, the pain being substernal or precordial, sharp, affected by position, and occasionally in the upper abdominal area, the occurrence of fever and leukocytosis and of characteristic electrocardiographic and roentgenographic findings have already been mentioned in the discussion of general diagnosis. The course of this disease lasts a few days to several weeks. There may be pleurisy with effusion or pneumonitis associated.

All in all, the diagnosis of acute idiopathic pericarditis is made on the general clinical picture mentioned, the signs of pericarditis, and the absence of other causes of pericarditis. Confusion with and differentiation from myocardial infarction is important, as already indicated. Similarly, other causes of anterior chest pain sometimes require consideration; otherwise differentiation from other types of pericarditis is the chief problem. Because of fever and frequently preceding upper respiratory infection, findings in general often seen in infections, infection as the cause of acute idiopathic pericarditis has often been postulated. A viral agent has been uppermost in the minds of many observers. However, none has ever been established.

"Absence of Other Causes"

In the diagnostic criteria, emphasis must be placed upon "absence of other causes." This statement implies that one does not accept the simple clinical picture alone, but has made an effort to rule out other diseases as possibly etiologically related. Tuberculous pericarditis is sometimes differentiated with difficulty. The clinical picture may be similar. Indeed, tuberculosis may be obviously present in the lungs and produce pericarditis by contiguity of the infection. It may also, in the miliary type, involve the pericardium. In both of these latter circumstances confusion with acute idiopathic pericarditis is not likely.

However, there is a third type of tuberculous pericarditis in which clinical evidence of disease does not appear elsewhere, and the presenting clinical picture is primarily pericarditic. In this group differentiation from idiopathic pericarditis is difficult. Absence of precordial pain in the tuberculous variety is often given as

a helpful feature. Both types may have little pain at times. There is a greater tendency for tamponade in the tuberculous type. Culture and animal inoculation of pericardial fluid may be necessary to establish the diagnosis of tuberculosis and the tuberculin test, particularly if negative, is helpful in ruling it out. Pericardial biopsy may be considered if necessary. The importance of the differentiation is evident, for failure to establish the diagnosis of tuberculous pericarditis denies the patient sorely needed specific therapy.

Although acute idiopathic pericarditis has been assumed by some investigators to be viral in origin, this clinical picture has been found only occasionally with specific virus infections. In these instances it is very likely that the viral disease concerned involves the pericardium as a part of the total viral picture and that the disease represents, etiologically, a different process. Coxsackie virus, for example, has been found in the pericardial fluid in some instances. Significant change in blood antibody titer has also been reported at times. The clinical picture has also been found as a part of influenza[4] and in influenza epidemics. Cardiac complications often occur in convalescence or after seeming recovery. Thus the relationship of infection, latent period, then pericarditis occurs as in acute idiopathic pericarditis. If the primary infection has not been established as influenza there may be no association recognized.

Other Infectious Types

Other infectious types of pericarditis, especially purulent pericarditis of pyogenic origin, are generally easily differentiated because of association with generalized pyogenic disease or with proven pulmonary processes. If such infections are modified by inadequate chemotherapy, differentiation may be more difficult, especially if such chemotherapy was not based on bacteriologic study.

Rheumatic and uremic pericarditis, because of related findings, offer little difficulty.

Importantly, because of therapeutic and prognostic considerations, the clinical picture of acute idiopathic pericarditis at times appears as a part of, or as the initial feature of, lupus erythematosis disseminatus.[5] There are a number of features aside from the usual clinical expressions of pericarditis which are similar. Precordial pain occurs, but is less frequent in lupus. There may be recurrent bouts of pericarditis. This is a characteristic feature in acute idiopathic pericarditis, but the fact that recurrence also occurs in lupus means that when recurrences do appear the possibility of lupus must be considered.

Fever occurs in both of these processes, but may be prolonged beyond the usual seven to ten days in lupus or in other specific types of pericarditis. Preceding upper respiratory infection is quite common in idiopathic pericarditis but unusual in the attacks of pericarditis associated with lupus. Lupus also favors females. The idiopathic type tends to favor males. In addition, in lupus there may be the findings often found in lupus generally. These include elevation in blood pressure, unexplained congestive heart failure, the skin rash, lymphadenopathy, hepatomegaly, splenomegaly, leukopenia, anemia, hematuria and proteinuria, elevations in serum globulin, a positive serological test for syphilis, and obviously the positive LE phenomenon.

In addition, one of the characteristic findings of disseminated lupus is the presence of multiple organ involvement. Therefore, disease beyond the lungs and pleura is likely to indicate a process above and beyond that of acute idiopathic pericarditis.

It is evident that, in the diagnosis of acute idiopathic pericarditis, consideration must be given to other possible processes for the development of the clinical picture at hand. This can only be done if a positive and deliberate approach is utilized.

Conclusions

1. Acute pericarditis is more frequent than usual clinical experience indicates. Diagnosis is frequently missed.

2. Acute pericarditis as a part of a general clinical picture, especially with onset late in the disease, is often not recognized because of the over-shadowing general picture.

3. The diagnostic signs of acute pericarditis are quite variable in their occurrence and must be deliberately sought. This means acute peri-

carditis must be suspected to be diagnosed. One must deliberately seek out the signs of pericarditis in the presence of disease known to be associated with this process and in thoracic symptoms not otherwise adequately explained.

4. The variable appearance and disappearance of friction and the rapid evolution of electrocardiographic changes and roentgenographic patterns make serial observations important in diagnosis.

5. The general course of the disease, along with non-specific electrocardiographic and roentgenographic findings, in the absence of friction, may be essential factors in arriving at a diagnosis.

6. Acute idiopathic pericarditis, one of the most common varieties, must be diagnosed only after diligent search for other causes has proved fruitless. Tuberculous pericarditis and the pericarditis of the acute disseminated lupus, two varieties which may at times simulate it closely, must be ruled in or out for important therapeutic and prognostic reasons. Certain helpful variations in clinical findings have been discussed.

7. It appears that the entity now called acute idiopathic pericarditis represents a group of processes due to more than one etiologic factor. At least the clinical expression attributed to acute idiopathic pericarditis may be due to more than one etiologic agent which may not be patently evident in the case studied.

8. The diagnosis of acute idiopathic pericarditis should not become final until time proves the diagnosis and eliminates known etiologic possibilities. The diagnosis should be let stand only with suspicion and distrust.

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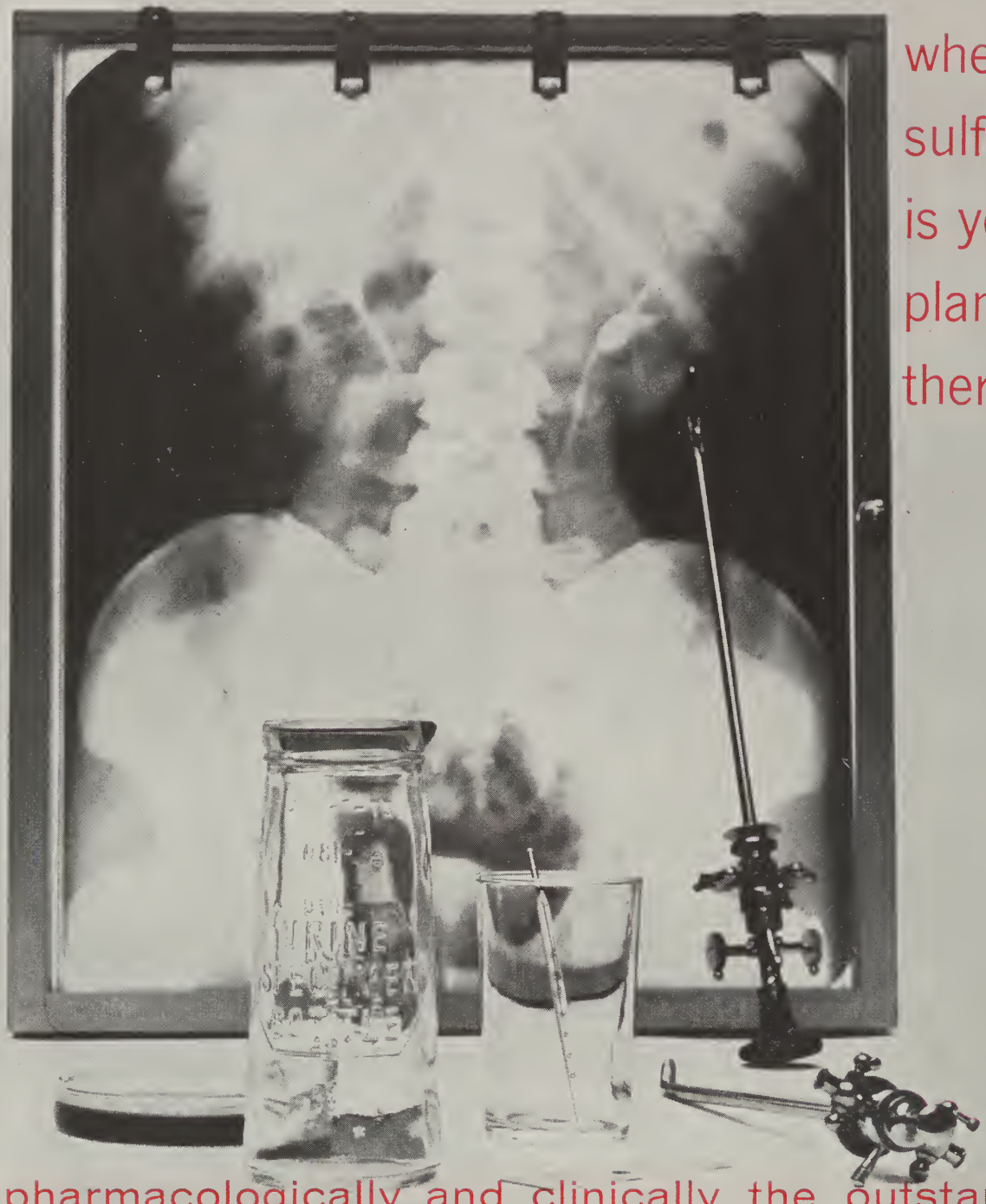
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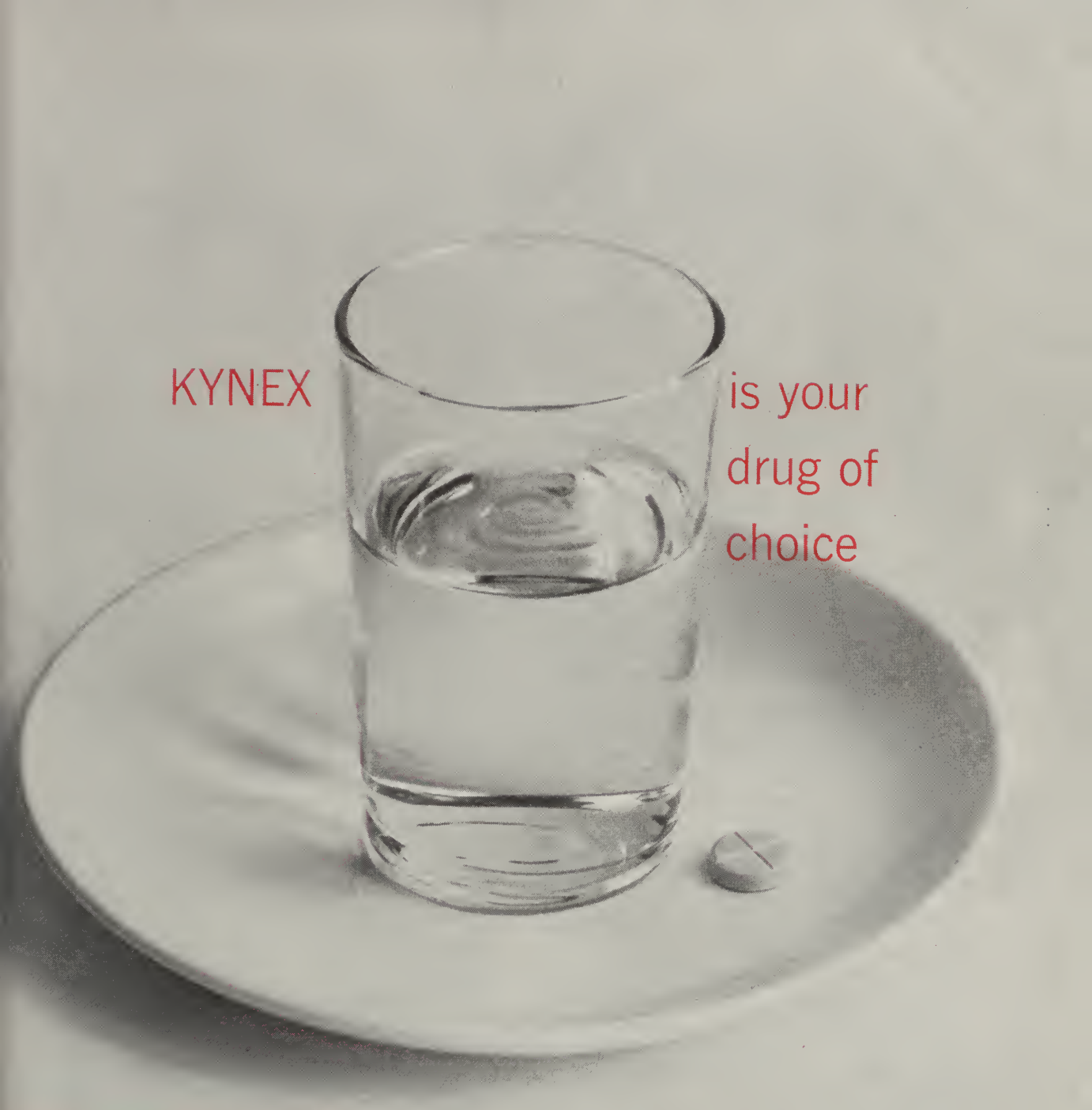
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Clinical Study Of Chloroform Anesthesia: A Preliminary Report*

Johnny G. Reynolds, M.D.

Donald M. Thomas, M.D. *Louisville, Ky.*

Eugene H. Conner, M.D.†

Importance of control of concentration of chloroform in the inspired atmosphere is emphasized in this report of limited experience with use of the agent for general anesthesia purposes

Introduction

SINCE its introduction into clinical anesthesia by Sir James Y. Simpson in 1847, chloroform has been one of the most used and yet most maligned of anesthetic agents. Most anesthesiologists today do not employ the drug because of a fear of deleterious effects on the heart and the liver. These fears are largely based upon work with chloroform which was done prior to the development of modern anesthetic apparatus and modern methods of supportive care.

The present investigation was undertaken at the Louisville General Hospital in an attempt to learn if chloroform would be a useful and safe anesthetic agent when used under carefully controlled conditions of dosage, ventilation and supportive therapy.

Historical Background

The history of the use of chloroform is marred by the stigmata of cardiovascular collapse and liver damage. Less than three months after its introduction as an anesthetic, the first death under chloroform anesthesia was reported.[1] This case, and others like it which were soon reported, seemed to be due to a sudden cessation of cardiac action during the induction of anesthesia with this drug. In spite of a lack of laboratory evidence, the early users of chloroform such as Snow,[2] Clover,[3] and others, recognized that the depressant action of chloroform on the heart was due to overdosage. Inhalers were designed that would limit the concentration of chloroform that the patient received. This concentration at first was set at 5%, but later was reduced to 2%. At least one early worker, Schafer,[4] felt that vagal inhibition of the heart might be a contributing factor in chloroform depression of the circulation, and in 1880 he suggested the use of premedication with atropine to avoid this effect.

A number of quasi official committees were appointed to study this problem of chloroform dosage and the heart, the most notable being the Special Chloroform Committee of the British Medical Association[5] which applied a sound scientific method to the study of the problem. Their final report published in 1910 showed that overdoses of chloroform exerted direct depressant action on the myocardium, that hypoxia and hypercarbia increased the degree of depression and that blood oxygen content could decrease during anesthesia even though

* *Presented before the Kentucky Society of Anesthesiologists during the Annual Meeting of the Kentucky State Medical Association on September 22, 1959.*

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respiration appeared normal. Their initial conclusions still stand. They took a firm stand that chloroform does not kill unless overdosage occurs, and that in vapors of 2% concentration or less, chloroform is a safe drug. The importance of having close control of the inspired concentration when administering chloroform has again been stressed by Waters[6] and his colleagues as a result of their recent study.

The history of liver damage from chloroform is somewhat shorter. Although a few early users of the drug reported jaundice occurring after chloroform anesthesia, they did not connect the two observations as cause and effect. According to Howland and Richards,[7] the first death in man from the hepatotoxic effect of chloroform was reported by Thiem and Fischer in 1889, and other accounts soon followed. It should be remembered that all these reports came from an era when intravenous fluids, blood transfusion, preoperative care and other supportive measures were unknown and when patients were exposed to large quantities of hepatotoxic antiseptics such as phenol.

'Delayed Chloroform Poisoning'

By 1905, the term "delayed chloroform poisoning" had become firmly entrenched in the medical literature and accurate descriptions of the pathological process were recorded by Howland and Richards,[7] Whipple and Sperry,[8] and others. The beneficial effects of good nutrition in this condition were shown by Hunter[9] in 1908, but he lacked the means to carry out his ideas, and only recently has it been possible to support the surgical patient by intravenous feedings of glucose and electrolytes. In 1937, Goldschmidt, Ravdin and Lucké[10] showed that the hepatotoxic effects of chloroform could be greatly reduced by administration of oxygen during anesthesia.

In 1950, Waters[6] and his associates carried out an extensive study of chloroform anesthesia under modern conditions of surgical and anesthetic management. They concluded that chloroform properly administered was a safe drug, but still felt the need for a vaporizer that could give really accurate control of the inhaled concentration.

Recently two vaporizers of great accuracy have been introduced, namely the Copper Kettle designed by Lucien Morris[11] and available from Foregger & Co., and the Vernitrol of the Ohio Chemical Company which was designed by William Haye. The availability of vaporizers that would produce accurate vapor concentration even at very low concentrations prompted us to undertake the present study.

Materials and Methods

Sixty-five chloroform anesthetics were administered to 62 unselected patients ranging in age from 20 months to 88 years. The duration of anesthesia was 30 minutes to 10.5 hours. Anesthesia was induced either with a sleep dose of Thiopental Sodium, or with chloroform-nitrous oxide-oxygen. When intubation of the trachea was performed, Succinylcholine-chloride 40-60 mgm. was used to provide muscular relaxation in most cases. The concentration of chloroform was not allowed to exceed two per cent.

Anesthesia was maintained with chloroform-nitrous oxide-oxygen in a semi-closed system with carbon dioxide absorption and high flows (6 L. of nitrous oxide to 2 L. of oxygen). During maintenance, chloroform concentrations was held below 1.0%, and were usually in the range 0.4—0.6%. Succinylcholine by intravenous drip of 0.2% solution was used as needed to provide muscular relaxation without employing deep planes of anesthesia.

In all cases, chloroform was vaporized by the Copper Kettle or Vernitrol vaporizers, and the concentration was determined by reference to a nomogram for chloroform[12] or the Ohio Chemical Flow Calculator. Great care was used to insure adequate ventilation by controlled or assisted respiration, and to maintain oxygen concentrations above 25% in the inspired atmosphere. All patients received intravenous infusions of 5% glucose in water during and after operation to maintain adequate hydration. Post-operative care did not vary from that routinely followed in this institution.

The changes in Thymol Turbidity and Cephalin Cholesterol Flocculation tests of hepatic function were followed during this study. These tests were selected because changes in either of these tests is indicative of parenchymal changes in hepatic tissue.

Results

There were no deaths attributable to anesthesia in the 62 patients studied. One patient died of a pulmonary embolus on the ninth post-operative day. An autopsy confirmed the cause of death and the liver appeared normal both grossly and microscopically.

Liver function studies were carried out in 31 patients. The Thymol Turbidity and Cephalin-Cholesterol Flocculation tests were done pre-operatively and on the fourth and tenth post-operative days. In 26 cases, or 84% of those studied, there was no change or an improvement in the post-operative values obtained as compared to the control values. In five patients, or 16% of the studied group, some increase in one or both tests was found. Clinical jaundice occurred in one patient (E. B.) whose other liver function studies appear in line three of Table 1. This icterus appeared on the fifth

TABLE 1

Patient	Operation	Duration hrs.	Duration min.	Cephalin Floc. C.	Cephalin Floc. 4d	Cephalin Floc. 10d	Thymol. Turb. C.	Thymol. Turb. 4d	Thymol. Turb. 10d
L. W.	Elev. Depr. Fx. Skull	1	30	Neg.	Tr.	Tr.	1.4	9.6	4.6
E. S.	Sp. Fusion	3	0	Neg.	2+	2+	3.6	3.6	--
E. B.	Gastrect.	3	0	4+	4+	--	7.9	9.2	--
E. McC.	Neck Dissect.	3	30	1+	2+	Tr.	3.2	5.4	3.0
B. R.	Neck Dissect.	4	10	Neg.	Neg.	4+	3.0	4.2	4.6

C - Control
4d - 4th day post anesthesia
10d - 10th day post anesthesia

post-operative day and cleared by the time the patient was discharged on the tenth post-operative day.

Patients upon whom no liver function studies were performed were followed clinically by frequent post-operative visits. There were no complications observed in this group.

Serious difficulty with regard to the cardiovascular system was encountered only once in this series of 65 chloroform anesthetics. This patient will be discussed in detail later. With this single exception, there were no disturbances of cardiac rhythm noted clinically. EKG observations were not done on a sufficient number of patients to warrant discussion here. Hypotension greater than 20 mm. of mercury from the pre-operative blood pressure level was observed in seven cases. In no case was this hypotension sustained for longer than 10 minutes, and all instances responded promptly to a reduction in inspired chloroform concentration or the administration of blood when this was indicated. With one exception, no vasopressors were given. Hypotension was not observed during induction of chloroform anesthesia in any case.

Discussion

The importance of carefully controlling the dosage of chloroform in the prevention of accidents with this drug has been repeatedly stressed by many authors. Waters, et al studied hepatic function in 121 patients, 65 of whom received various anesthetic agents. No significantly different effect on the liver could be demonstrated following the use of chloroform when compared to changes produced by other anesthetics that had been administered to the control group. Our findings with regard to chloroform and liver function form a striking parallel to the findings of Waters.[6]

Textbooks of pharmacology[13] state that chloroform produces profound depression of the cardiovascular system with either sudden collapse, or progressive fall in blood pressure during anesthesia. These phenomena were not observed in this study, where the concentration of chloroform was under close control, and adequate ventilation was assured.

The safe administration of chloroform anesthesia depends on three principles:

(1) Accurate control of the concentration administered.

(2) Careful attention to provide adequate ventilation and avoid hypoxia and hypercarbia.

(3) *Alert* observation of patient at all times.

Case Record

The importance of following these principles is illustrated graphically by the following case, to which reference has already been made.

Figure 1 shows the anesthetic record of a 34-year-old, very obese, colored female undergoing urethroplasty in the lithotomy position. While the chloroform concentration was controlled, respiration was not supported adequately as indicated by the rising pulse rate, blood pressure and respiratory rate. This was suddenly recognized and assistance of depth of respira-

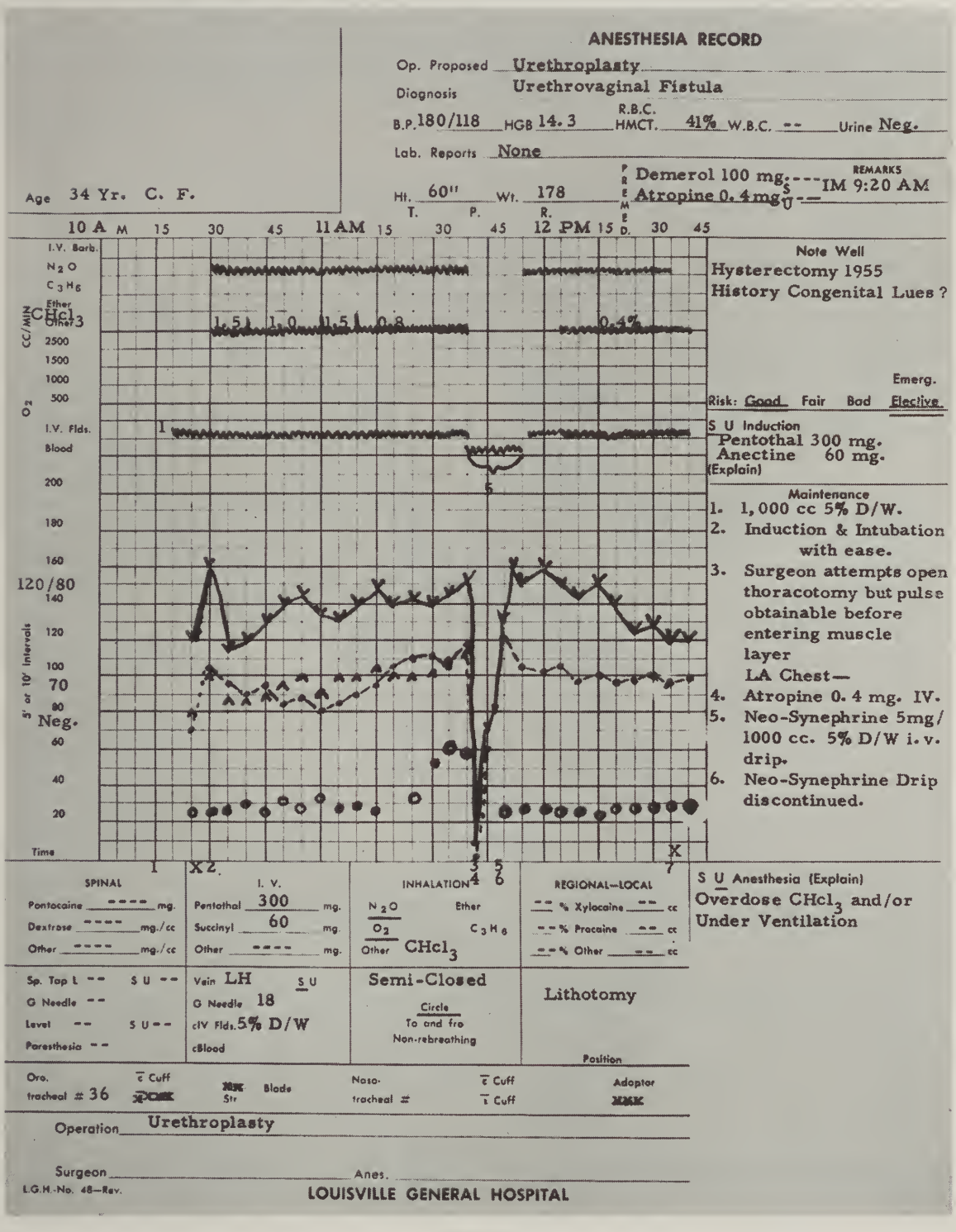


Figure 1

This is the anesthetic record of a 34-year-old, very obese female undergoing urethroplasty in the lithotomy position.

tion was provided by manual compression of the rebreathing bag. This was instituted without decreasing the chloroform concentration in the inspired atmosphere. Overdosage, with resultant cardiovascular collapse occurred within a few seconds. Chloroform was discontinued and the patient ventilated with 100% oxygen while the surgeon began thoracotomy. As the skin was being incised, the pulse returned and the blood pressure became obtainable. Ten milliliters of a 0.005% phenylephrin in 5% Glucose as an intravenous infusion were given but promptly discontinued. The operation was finished without further incident under a *reduced* chloroform concentration and controlled respiration. The patient made an uneventful recovery.

Summary

Sixty-five chloroform anesthetics given at the Louisville General Hospital are reported. Liver function tests were carried out in 31 of these cases, and the results showed a lack of significant damage to the liver following chloroform anesthesia.

The importance of controlled dosage, adequate ventilation and careful observation to insure the safe conduct of chloroform anesthesia was illustrated.

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Meeting the Socio-Economic Challenges of the 60's

10th Annual County Society Officers Conference

March 31 at Gabe's Restaurant, Owensboro

Top-notch Speakers • Simulated Congressional Hearing

Reserve Thursday, March 31, for this Important Conference

Louisville General Hospital*

Endometrial Carcinoma

History

S. M., an 82-year-old Negro gravida 1, para 1, 40 years postmenopausal, was first seen on October 5, 1959, with the chief complaint of vaginal bleeding for approximately one year. She gave a history of normal, regular menstrual bleeding up until the time of the menopause 40 years prior to admission. There was no further vaginal bleeding until approximately one year before the present admission, when she began to notice vaginal spotting of bright red blood at irregular intervals. She stated that sometimes two or three weeks would intervene between bleeding episodes. During the past several months the bleeding had steadily increased in both frequency and amount, and at the time of admission the patient was using two perineal pads daily. The bleeding was consistently painless and did not worry the patient.

The patient gave a history of chronic hypertension for several years. She was treated for this for approximately two years, the treatment starting about one year before the onset of the bleeding. Treatment consisted of the administration of oral medication; this was administered by a private physician, and the nature of the medication was not known by the patient. Apart from this hypertensive disease, the patient had no history of operation, accidents or serious illnesses. She had had an abdominal mass for many years, but this was not uncomfortable.

Physical Findings

The patient appeared well preserved for her 82 years. The blood pressure was 148/84, pulse 80. The chest was clear to percussion and auscultation. On auscultation of the heart, a regular sinus rhythm was noted with a grade 1 systolic murmur over the precordium. The remainder of the general physical examination was well within normal limits for a patient of this age.

The abdominal and pelvic findings were as follows: the abdomen was moderately protuberant with a sensation of a rubbery mass palpable above the umbilicus with several firm masses in both lower quadrants. The outlet was atrophic. The cervix was difficult to visualize because of vaginal stenosis near the apex, but it was ultimately possible to visualize it and no lesions were seen. The uterus was diffusely enlarged by firm, nodular, rounded masses corresponding to the areas felt abdominally. These masses had a rubbery consistency on the left side and were somewhat tender on the right. The parametria were not indurated.

Laboratory findings were as follows: a plain film of the chest showed the heart to be normal as to size and configuration, with both lungs symmetrically expanded and without abnormalities. There was slight elevation of the right hemidiaphragm and a slight displacement of the trachea to the left which was thought possibly to be due to an enlarged thyroid. A recumbent supine examination of the abdomen showed the elevation of the right hemidiaphragm and a large calcific mass, amorphous in structure, measuring about 14 cm. in greatest diameter. The roentgenologist interpreted this as probably representing a calcified uterine fibroid. The hemoglobin was 12.7 grams; WBC 8,400 with normal differential; VDRL non-reactive. Urinalysis was negative for albumen and sugar with occasional epi-

Patient Protocol #322695

thelial cells and many bacteria on microscopic examination.

Treatment And Course

Because of the postmenopausal bleeding, the patient was taken to the operating room on October 7, 1959, and a dilatation and curettage was performed. Examination under anesthesia at this time showed that the cervix was flush with the vaginal wall. The uterus was enlarged to the umbilicus and extended laterally to both pelvic walls; it was freely movable. The previously described irregular nodules were readily palpable. The uterine cavity was sounded to a depth of four inches and was found to be extremely irregular. A curettage was performed without producing any recognizable gross endometrial tissue, even on sharp curettage. A four quadrant cervical biopsy was taken. Bleeding was minimal and the patient withstood the anesthesia well. The histological study of the uterine scrapings and cervical biopsy tissue was reported as showing insufficient endometrium for diagnosis together with fragments of myometrium and chronic cervicitis.

Since the postmenopausal bleeding had been objectively observed, the staff consultant was not willing to accept the negative endometrial curettage as representing evidence that the patient did not have endometrial carcinoma, and accordingly a second operation was undertaken on October 13, 1959.

At this time, median laparotomy was performed and the uterus was found to be enlarged to the size of a large grapefruit by the previously described nodular, irregularly-shaped, firm, calcified leiomyomas. The tubes and ovaries appeared atrophic and there were a few loose adhesions to the sigmoid and the small intestine to the posterior surface of the uterus; these adhesions were easily separated, and the uterus was then freely movable and could be lifted out of the abdominal incision. The uterovesical peritoneum was incised transversely from one round ligament to the other and the bladder reflected downward in the manner usually used for hysterectomy. A total abdominal hysterectomy and bilateral salpingo-oophorectomy were then performed, care being taken not to place tenacula or other instruments into the fundal tissue. The entire specimen was removed in a single mass.

When the uterus was opened after its removal, there were numerous calcified myomas in the wall. The endometrial cavity was small, but at the fundus in a place that would have been inaccessible to a curette, there was a friable, necrotic mass of tissue which grossly was thought to represent either a degenerated myoma or, more likely, a small, localized endometrial carcinoma. It was thought that this might well represent the area from which the postmenopausal bleeding must have occurred. It appeared grossly to be well localized in the endometrium. The myomas were not incised at the time of the operation so that no anticipation of spillage was present. On histologic examination, a section from the area described showed it to represent an endometrial adenocarcinoma with deep invasion of the myometrium and focal vascular invasion seen in some of the sections. The other diagnoses were uterine leiomyomas, atrophic ovaries, chronic cervicitis and normal atrophic fallopian tubes.

The subsequent hospital course of the patient was entirely uneventful, and she was discharged on October 19 in good general condition. There were several follow-up examinations in the clinic, the last of which was on December 17, 1959, at which time the patient was in good condition with no new findings on physical examination.

Discussion

Douglas M. Haynes, M.D.

This patient illustrates quite dramatically the principle that any patient with postmenopausal bleeding must be subjected to diagnostic curettage if her best interests are to be served. Another point worthy of mention is the extreme unlikelihood that leiomyomas of the uterus will produce bleeding after the menopause. Such tumors will have been present for many years, and only in the unlikely event that sarcomatous degeneration occurs in the myomas would either uterine enlargement or postmenopausal bleeding result from the myomas themselves in this age group. Therefore, when a postmenopausal woman with a myomatous uterus exhibits bleeding from the uterine cavity, intensive search must be made for some lesion other than the myomas to explain the bleeding.

In the case described, the diagnostic curettage which would ordinarily be expected to yield the diagnosis of endometrial carcinoma did not

produce enough tissue to establish that diagnosis because of distortion of the endometrial cavity so that the curette did not reach the carcinomatous area. The same distortion of the endometrial cavity would have prevented the application of intracavitary irradiation even if the presumptive diagnosis could have been made by some other means. Accordingly, it was elected to perform definitive surgical removal of the uterus and adnexa. This patient's prognosis is fairly hopeful because of the lack of spread of the lesion beyond the endometrium.

The duration of this patient's symptoms are fairly characteristic of many cases of endometrial carcinoma. This lesion may persist for a long time without causing any significant symptoms, and then symptomatology may be irregular bleeding of a type which does not alarm the patient. An important part of the prophylaxis for this disease consists in education of the public so that any patient with postmenopausal bleeding will consult her physician promptly. Careful diagnostic curettage should be made in all cases, and the presence of uterine leiomyomas tends to substantiate rather than weaken the suspicion of carcinoma because of the statistical fact that there is an increased incidence of endometrial carcinoma in myomatous as compared with non-myomatous uteri in the age group concerned.

The prognosis for carcinoma of the uterine fundus is favorable as long as the tumor remains confined to the endometrial cavity. The definitive therapy consists of total hysterectomy and bilateral salpingo-oophorectomy. Since the tumor extends down into the cervical region and metastasizes to the pelvic lymph nodes in only about 15 per cent of the cases, and since the age group for this tumor is usually fairly advanced, pelvic lymph node dissection is rarely if ever indicated in the primary treatment. The indications for radical operative attack are further diminished by the association of hypertensive disease, obesity and diabetes in many of these patients. If the carcinoma has spread beyond the uterus, the prognosis is poor and the operative attack is likely not to be curative. The metastases may frequently be in the ovary; the carcinoma cells spread either by lymphatic continuity or through the fallopian tubes. Multiple metastases in the peritoneum associated with ascites may be occasionally seen but are rare, whereas early metastases to the vagina have been reported somewhat more commonly.

Many studies tend to confirm the impression that the operative results can be improved by intrauterine radium application four to six weeks prior to the operation. The reason for the increased salvage made possible by the preoperative radiation therapy is not known, but may be twofold: first, there may be shrinkage of a bulky tumor mass, rendering less likely the chance of perforation of the involved area from outside; and second, any spillage which may occur at the time of the operation may be less dangerous because of radiation-induced degenerative changes in spilled carcinoma cells which may render them less liable to implantation.

Under optimum conditions with the tumor confined to the uterus and definitive surgical therapy with or without radiation, it is reasonable to expect a five-year cure rate of 80 per cent or even slightly better. The cure rate of radiation alone is lower because poor operative risks and inoperable cases are included. However, a five-year cure rate varying between 39.5 and 71.4 per cent following treatment with radiation alone has been reported from Radiumhemmet in Stockholm by Kottmeyer, and if cases are selected who might equally well have been treated with surgery the radiation results compare favorably with the surgical results. Current thinking on this subject firmly endorses the basic principle that this disease is primarily a surgical problem, however.

Some of these patients may be suspected of harboring the disease on the basis of vaginal smears, but in general the Papanicolaou technique has not proved as valuable in the screening of patients with endometrial carcinoma as it has in patients with carcinoma of the cervix. Curettage remains the definitive diagnostic procedure for all patients with postmenopausal bleeding, and endometrial carcinoma must be ruled out in all such patients, whether by curettage or by the definitive operation of total hysterectomy and bilateral salpingo-oophorectomy, as was the case in the patient described.

Advanced age is not by itself a contraindication to this operation. For example, the indicated procedure was tolerated extremely well by the patient being discussed.



Joint Commission Defines Responsibilities Of Hospital's Governing Body*

THE Standards for Hospital Accreditation state that "the governing body has the legal and moral responsibility for the conduct of the hospital as an institution. It is responsible to the patient, the community, and the sponsoring organization. Its official representative is the chief administrative officer of the hospital."

For the hospital to be accredited, the Commission requires that the governing body assume its responsibilities. For effective performance, it should do the following:

1. Adopt bylaws in accordance with legal requirements.
2. Meet at regular stated intervals.
3. Appoint committees. There should be an Executive Committee and others as indicated for special purposes.
4. Establish a formal means of liaison with the medical staff, preferably by a Joint Conference Committee.
5. Appoint members of the medical staff.
6. Appoint a qualified hospital administrator who is the official representative of the governing body. The administrator is responsible for the conduct of the hospital, and provides liaison among the governing body, the medical staff, the nursing staff, and other departments of the hospital.

In the discharge of its duties, the governing body must obviously place the responsibility for the medical care of the patient primarily upon the medical staff. Only physicians can practice medicine; however, the governing body is responsible for the environment, facilities and personnel necessary for physicians to practice medicine effectively in the hospital.

For the welfare and safety of patients, very close liaison must exist between the governing body and the medical staff. Each group must respect the prerogatives of the other, accept fully its own responsibilities, and understand each other's problems. This can be accomplished only if there are good communication, effective organization and willingness to work together. Power politics has no place in the hospital.

The governing body appoints the administrator, formalizes his responsibilities, and delegates to him the internal operation of the hospital. It holds the administrator accountable for operating the hospital in accordance with established policies. It formally approves the organization, bylaws, rules and regulations of all groups operating within the hospital. It receives from all departments and groups those reports necessary to enable it properly to evaluate the operations of the hospital.

The Commission recognizes that the ultimate authority and responsibility for the conduct of the hospital lie in the governing body. To exercise its authority and carry out its responsibilities for the care of patients, it needs the help, counsel and active participation of all professional and administrative groups in the hospital.

Nursing Service

It is axiomatic that adequate nursing service to patients is essential if a hospital is to be accredited. In evaluating the nursing service, the Commission asks this fundamental question, "Is the nursing service adequate to give safe care?" Judged by standards of excellence, the standards of the Commission are the very minimum for rendering safe care to patients.

For accreditation of a hospital, graduate nurse coverage on a 24-hour basis for all patients is required. There must be a graduate nurse on duty at all times to assume responsibility for the bedside care of patients. This requirement of the Commission is based on the fact that judgment is required to insure the safety of patients and only a graduate nurse has the knowledge and educational background to exercise this judgment. This means that if a nursing aide or licensed practical nurse is on duty during the evening and night hours in a ward with patients who do need skilled nursing service, there must be a graduate nurse supervisor who makes frequent rounds and is available at a moment's notice to give skilled nursing care. She must be free to render bedside care and must not be tied up in the operating

(Continued on Page 371)

**Bulletin of the Joint Commission on Accreditation of Hospitals; Kenneth B. Babcock, M.D., Director.*

EDITORIALS

Our Position Clarified

Recently, an address which I gave as the retiring president of the Jefferson County Medical Society received some attention in our newspapers. For this, I am flattered and duly grateful. However, some of the material has been taken out of context, quoted and "slanted" by some outside of our profession, to indicate a reversal of our attitude toward the socialistic pressures on all phases of our American life today. Nothing could be further from the thought and intent behind the remarks made in the address.

We, as a profession, will keep abreast of the ever-changing socio-economic conditions of our country. When change is indicated, in order to furnish better and more complete medical care for our people, the medical profession should, and must, be the guide and adviser in such change. If we do not fulfill our mission in this field, the changes brought about will, in all probability, fall short of their objectives and the public and the medical profession will suffer the consequences.

There has been much said and written in regard to "Third Party" Medicine, during the past two or three years. We, as a profession, know that this facet of medical care has been with us for a long time, and that it has recently involved more and more of our profession in the dispensing of it. It is anticipated that more and more of our people will be covered by voluntary insurance plans, so that a minimum of non-medical direction will be in evidence. A solidly-united medical front is essential, if we are to reach and maintain our rightful position as guide and adviser, as well as dispenser, in this expanding field.

"Third Party" Medicine, as it is generally administered, leaves much to be desired in furnishing the best and most complete medical care to our people. Our goal should be to furnish the best possible medical care under these or any other plans; insist, by means of a united front, on our rightful voice in policy and administration, as well as dispensing this facet of medical care. This can best be accomplished by putting aside any prejudices, accepting the inevitability of change, and working with all our resources to help make manifest to all concerned that doctors not only can, but do, offer the best and most satisfactory medical care, if allowed their rightful voice in policy making and administration of medical care plans.

Foster D. Coleman, M.D.

1960 Legislative Action

EVERY Kentuckian must be watching with a great deal of interest the activities of our present Legislature. When during the recent campaign the successful candidates for Governor and Lieutenant-Governor promised action in the coming legislative session, they evidently intended exactly what they said. Whether or not we are sympathetic with their plan or manifested our endorsement with our vote, we must admit that they have undertaken an ambitious program.

We are bound to be sympathetic with any person or group of persons so long as their efforts appear to be honestly directed toward the welfare of the Commonwealth of Kentucky and its citizens. Without placing our endorsement upon every single feature of the present legislative program, we do feel that an earnest attempt is being made to improve our general welfare.

One who has attended the legislative sessions in Frankfort is bound to be impressed by the sincerity and earnestness, and, often, the comprehensive understanding of issues displayed by our lawmakers. We believe them in general to be well-informed, honest men seeking to improve the political, educational and economic condition of our State.

Rep. Pat Tanner, of Owensboro, sponsors a "conflict of interest" bill. His announced intention is to stop state officials from participating in transactions for personal enrichment by use of their official influence. The bill provides that a Legislator or official may do business only on a competitive bid basis with the State. The head of a state office may not act as an agent for his own business or personal interests before his own bureau, directly or indirectly. Legislators, unless they resign their seat, are forbidden to take another job on the State payroll.

Editorial comment over the State has been favorable, since many states and the Federal government have "conflict" laws. The Governor and the Lieutenant-Governor in their campaign, and recently again, expressed themselves as favoring a good "conflict of interest" law. We congratulate Representative Tanner on this 3-year campaign.

The "Quick Cremation" bill had no opposition in the Senate. It undoubtedly has merit and we believe it will pass the lower chamber when it is placed on the floor for a vote. The "Anti-Quackery" cancer bill fared well in the House, and after lively debate in the Senate passed by the landslide of 34 to 3. This completed measure appears to be progressive.

We have been more concerned perhaps with the enactment of provisions for adequate Indigent Medical Care throughout the state than any other part of the health program. The Allied Medical Council has unanimously agreed upon the basic issues of the Indigent Medical Care program. If handled as a part of the Administration's Reorganization program, it is not so likely to be subject to destructive changes or amendments. We trust that this can be done.

To date this biennial legislative program appears constructive and sound. We have every hope that it remains so. The State Medical Association has an obligation to the citizens of Kentucky to sponsor and support sound health legislation. We shall continue to try to choose and encourage that which is best.

Sam A. Overstreet, M.D.

ORGANIZATION SECTION

Plans Complete For Officers Conference March 31

All roads will lead to Owensboro on March 31 for Kentucky physicians—their destination, the 10th Annual County Society Officers Conference at Gabe's Restaurant.

With the date less than a month away, preparations have been completed for a program designed to interest all KSMA members. A nationally-known physician-Congressman, two AMA authorities on medical legislation, and the president of the National Conference of Blue Shield Plans are slated as speakers. In the nature of a surprise will be a simulated Congressional Committee hearing.

The complete program follows:

Morning Session

Irvin Abell, Jr., M.D., Louisville, President, Kentucky State Medical Association, Presiding

9:00 a.m. **Registration**

9:45 a.m. **Coffee Call**

10:00 a.m. **Call to Order and Announcements,** Dr. Abell
Invocation, Dr. Jess Moody, pastor of First Baptist Church, Owensboro.
Welcome, Jack C. Blackstone, M.D., Owensboro, president of Daviess County Medical Society
Remarks from the Secretary, Woodford B. Troutman, M.D., Louisville

10:15 a.m. **"How Changing Public Attitudes Affect Medicine"**
Gerald J. Skibbins, Princeton, N. J., research executive of Opinion Research Corporation

10:40 a.m. **"Quo Vadis"**
F. L. Feierabend, M.D., Kansas City, Mo., president of the National Conference of Blue Shield Plans

11:05 a.m. **Coffee Break**

11:15 a.m. **"Effectively Meeting Our Adversaries"**
Ernest B. Howard, M.D., Chicago, assistant executive vice-president of AMA

Luncheon Session

Irvin Abell, Jr., M.D., Presiding

12:30 p.m. **"The Legislative Challenge That Medicine Faces"**
Dale Alford, M.D., Congressman from Little Rock, Ark.

Afternoon Session

Richard G. Elliott, M.D., Lexington, President-Elect, Kentucky State Medical Association, Presiding

1:45 p.m. **Simulated CONGRESSIONAL COMMITTEE**
(Considering the Forand Bill—HR 4700)
Moderator—C. Joseph Stetler, Chicago, Director, AMA Law Division
Other Participants—Ernest B. Howard, M.D., Chicago; Woodford B. Troutman, M.D., Louisville; George Archer, M.D., Prestonsburg; Wyatt Norvell, M.D., New Castle; O. Leon Higdon, M.D., Paducah, and others.

Dr. Harvey Active In Plans For White House Conference

Daryl P. Harvey, M.D., Glasgow, vice-chairman of the President's National Committee for the 1960 White House Conference on Children and Youth, will head the list of 56 Kentucky delegates to the Golden Anniversary Conference in Washington, D. C., March 27-April 2.



Dr. Harvey

The conference, the sixth called by a President of the United States since 1909 for a nationwide stock-taking of the needs of children and youth, will bring together some 7,000 persons from 52 countries. Representatives from 550 national organizations will participate, and 360 workshops will be held.

Doctor Harvey, the only Kentuckian ever to serve on the National Committee, has taken an active part in plans for the conference since his appointment by President Eisenhower in November, 1958. He has missed only one meeting of the committee which has convened on an average of every two months. He was chairman of the subcommittee which developed the theme, "To promote opportunities for children and youth to realize their full potential for a creative life in freedom and dignity."

Another Kentucky physician, Helen Fraser, M.D., Louisville, of the State Department of Health, is vice-chairman of the Kentucky Committee for the White House Conference.

Doctor Harvey holds a second Presidential appointment—membership in the President's Citizens Advisory Committee on the Fitness of American Youth.

He is president of the Kentucky Chapter of the American Academy of General Practice.

Pediatric PG Course Scheduled April 12 to May 31

The program for the 1960 Pediatric Postgraduate Course, to be given at the Children's Hospital, Louisville, on eight consecutive Tuesday mornings beginning April 12, has been announced by Alex J. Steigman, M.D., Professor of Child Health and Chairman of the Department of Pediatrics of the University of Louisville School of Medicine.



Dr. Steigman

The annual course is presented by the Department of Pediatrics, in conjunction with the Kentucky State Medical Association, the Kentucky Chapter of the American Academy of Pediatrics and the Kentucky Academy of General Practice. This year's program has been coordinated with the KSMA Committee on Postgraduate Medical Education, of which Walter S. Coe, M.D., Louisville, is chairman.

Emphasis will be placed on practical subjects, said Doctor Steigman. A clinical conference will be held each week for presentation of patients currently in the hospital. In addition, other interesting patients will be shown during the various discussion periods.

The program has been accepted as credit for Category I training. The registration fee will be $30.

The program follows:

Tuesday, April 12

9:30 A.M. **Welcome,** Alex J. Steigman, M.D.
Comments by:
State Chairman, AAP, Joseph A. Little, M.D.
Chairman, PG Committee of KSMA, Walter S. Coe, M.D.
KAGP, Homer Martin, M.D.

9:40 A.M. **Natural History of Left-to-Right Shunts,** Joseph A. Little, M.D.

10:30 A.M. **Conference**

11:30 A.M. **Preventive Role of the Physician In Well Baby Care,** Mary Cruise, M.D.

Tuesday, April 19

9:30 A.M. **Childhood Tuberculosis,** William C. Adams, M.D.

10:30 A.M. **Conference**

11:30 A.M. **The Value of Growth Studies,** Frank Falkner, M.D.

Tuesday, April 26

9:30 A.M. **The "Virus" Problem Of Everyday Infection,** Alex J. Steigman, M.D.

10:30 A.M. **Conference**

11:30 A.M. **The Physiological Basis Of Fluid Therapy,** Katharine Dodd, M.D.

Tuesday, May 3 (Surgery)

9:30 A.M. **Optimum Time for Elective Surgery,** Hugh B. Lynn, M.D.

10:15 A.M. **Case Presentation**

10:45 A.M. **The Limping Child,** S. Pearson Auerbach, M.D.

11:30 A.M. **Office Urology,** Robert Lich, Jr., M.D.

Tuesday, May 10

9:30 A.M. **The Diagnosis Of Rheumatic Fever,** Margaret Vermillion, M.D.

10:30 A.M. **Conference**

11:30 A.M. **The Ubiquitous Staphylococcus,** Joseph A. Little, M.D.

Tuesday, May 17

9:30 A.M. **The Newborn,** Mary Cruise, M.D.

10:30 A.M. **Conference**

11:30 A.M. **Meningitis,** Alex J. Steigman, M.D.

Tuesday, May 24

9:30 A.M. **Pediatric Diagnostrix** (Slides), Joseph A. Little, M.D.

10:30 A.M. **Conference**

11:30 A.M. **Iron Deficiency Anemia,** William C. Adams, M.D.

Tuesday, May 31

9:30 A.M. **Salicylism,** Katherine Dodd, M.D.

10:30 A.M. **Conference**

11:30 A.M. **Question Period,** Alex J. Steigman, M.D., and Postgraduate Faculty

Chairmen Named For Reunions Of Medical Graduates

As a part of the KSMA Annual Meeting, September 20-22, reunions of nine graduating classes of the University of Louisville School of Medicine are planned, according to KSMA President Irvin Abell, Jr., M.D., Louisville. Scheduled to meet are the classes of the years ending in O and 5.

Chairmen for the reunions are announced by George F. McAuliffe, M.D., Louisville, president of the Medical Association of the U. of L. School of Medicine. If you are a member of any of the following classes, your chairman would like to hear from you:

1915—Henry Reeder, 140 High Street, Jeffersonville, Ind.

1920—Karl Winter, M.D., Heyburn Building, Louisville 2.

1925—Everett Baker, M.D., 1207 Summit Avenue, Louisville.

1930—Marion F. Beard, M.D., Francis Building, Louisville 2.

1935—McDaniel Ewing, M.D., Heyburn Building, Louisville 2.

1940—George Sehlinger, M.D., Fincastle Building, Louisville 2; Medical Arts Building, Louisville 17.

1945—Robert Noland, 1974-A Douglas Boulevard, Louisville.

1950—Hoyt Gardner, M.D., Heyburn Building, Louisville 2.

1955—William Gillespie, M.D., Fincastle Building, Louisville 2.

New KSMA Members Listed

Two Lexington physicians are the newest members of KSMA. They are S. S. Shouse, M.D., and J. B. Parker, Jr., M.D.

KAGP Guest Speakers


Dr. Brush


Dr. Gifford


Dr. Lillehei


Dr. Meakins


Dr. Rynearson

KAGP Announces Program For Its Ninth Annual Meeting Set For May 11-13 At the Kentucky Hotel In Louisville

A staff surgeon from Henry Ford Hospital, Detroit, and staff members from 10 medical schools in the United States and Canada are scheduled to present the scientific sessions at the Ninth Annual Meeting of the Kentucky Academy of General Practice at the Kentucky Hotel in Louisville, May 11, 12 and 13.


Dr. Winters

Engaged for the banquet on Thursday evening, May 12, is one of the nation's foremost speakers, Dr. Carl S. Winters, pastor of the First Baptist Church, Oak Park, Ill.

James W. Davis, M.D., Louisville, chairman of the KAGP Committee on Scientific Assembly, which arranged the meeting, has announced the following program:

Wednesday, May 11

9:00 A.M. **Diagnosis of Islet Cell Tumors,** Brock Brush, M.D., Detroit

9:30 A.M. **Ophthalmic Referrals In General Practice,** Harold Gifford, M.D., Omaha

10:30 A.M. **Treatment of Goiters—Surgery or Radioactive Iodine?** Edward H. Rynearson, M.D., Rochester, Minn.

11:00 A.M. **Recent Advances In Surgical Treatment of Heart Disease By Open Cardiotomy,** C. Walton Lillehei, M.D., Minneapolis

1:30 P.M. **Kodachrome Clinic On Diseases of the Retina and Choroid,** Harold Gifford, M.D.

2:00 P.M. **Is Obesity An Endocrine Problem?** Edward H. Rynearson, M.D.

3:00 P.M. **The Use of Steroids In Surgical Conditions,** Brock Brush, M.D.

3:30 P.M. **Diagnosis and Surgical Treatment of Coronary Artery Disease,** C. Walton Lillehei, M.D.

Thursday, May 12

9:00 A.M. **Obstetrical Emergencies,** Simon V. Ward, M.D., New Orleans

9:30 A.M. **Problems In Immunization With Special Reference to Adults,** Samuel F. Ravenel, M.D., Greensboro, N. C.

10:30 A.M. **Management of Bronchitis and Emphysema,** Jonathan F. Meakins, M.D., Montreal, P. Q.

11:00 A.M. **Congenital Anomalies In Examination of the Newborn,** George J. Garceau, M.D., Indianapolis

1:30 P.M. **Treatment of Acute Glomerulonephritis In Children,** Samuel F. Ravenel, M.D.

2:00 P.M. **Some Particular Fractures For the General Practitioner,** George J. Garceau, M.D.

3:00 P.M. **The Obstetrician's Role in Rh Incompatibility,** Simon V. Ward, M.D.

3:30 P.M. **The Treatment of Refractory Pneumonias,** Jonathan F. Meakins, M.D.

Friday, May 13

9:00 A.M. **Acute and Chronic Glomerulonephritis** Ernest H. Yount, M.D., Winston Salem, N.C.

9:30 A.M. **Pediatric Urinary Tract Infections,** Matthew Marshall, Jr., M.D., Pittsburgh

10:30 A.M. **Pediatric Allergies,** Edward A. Troncelliti, M.D., Bryn Mawr, Pa.

11:00 A.M. **Evaluation of the Hypertensive Patient,** Ernest H. Yount, M.D.

The course is accepted for 10 hours, Category I credit.

Dr. Reckless Will Address President's Luncheon

John B. Reckless, M.D., Ch. B., of the Department of Psychiatry, Duke University Medical Center, has accepted the KSMA's invitation to address the President's Luncheon at the 1960 Annual Meeting in Louisville on Wednesday, September 21.

Doctor Reckless is in demand as a public speaker. His most recent appearance in this area was before the National Blue Shield Professional Relations Conference in Chicago in January.

Other plans for the Annual Meeting at Columbia Auditorium, Septembr 20-22, are moving along satisfactorily, committee chairmen report. J. Thomas Giannini, M.D., Louisville, chairman of the Committee on Scientific Exhibits, is receiving applications for space in the scientific exhibit. An application blank will be found on Page 368 of this issue of the Journal.

U. K.'s First Medical Students To Enroll Sept. 7

The University of Kentucky's new College of Medicine will register its first students on September 7, Dean William R. Willard, M.D., has announced.

The initial class will include about 40 students, with increases in subsequent years to a class of 75 when the college is under full development, Doctor Willard said.

As of February 11, a total of 410 applications for admission had been received. Of these, 37 candidates had been offered and had accepted places in the first class, leaving three places yet to be filled.

Doctor Willard noted that "we will have a class of medical students in 1960 that is equal to or better than the national average in quality. Since the quality of the student body is one of the more important determinates of the character and quality of the college, it is both important and gratifying that we have this prospect for our first year."

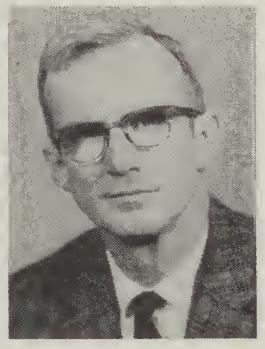
Doctor Willard also announed that the curriculum for the freshman year at the college has been approved. The program is a result of three years of study by staff members of the U. K. Medical Center, who visited more than half of the medical schools in the country for firsthand observation.

The first-year curriculum calls for 1,163 hours of classwork, divided as follows: Introduction to anatomy, microscopy and ultrastructure, 219; developmental anatomy, 56; behavioral science, 48; biochemistry, 209; physiology, 193; human growth and development, 108; conjoint sciences and systems, 122; genetics, 20; neurological system, 132, and introduction to clinical medicine, 56.

Doctor Willard explained that the introduction to clinical work, traditionally offered only to upperclassmen, is incuded in the program because "it is deemed important that study of the sciences basic to medicine not be restricted to abstract or theoretical consideration."



Dr. Deuschle



Dr. Carlson

College Gets Two New Chairmen

Two new department chairmen have been appointed for the U. K. College of Medicine by the University Board of Trustees.

Kurt W. Deuschle, M.D., a member of the faculty of Cornell University Medical School, was named head of the community-medicine department, starting July 1. Loren D. Carlson, Ph.D., a professor of physiology at the University of Washington School of Medicine, was selected as chairman of the department of physiology, effective April 1. Each will hold the rank of professor.



The Medical Science Building at the University of Kentucky Medical Center was the first unit to be occupied in the $26,000,000 Center. Shown here is the east part of the building.

Two Receive Research Grants

Medical-research grants totaling $123,570 have been awarded to two members of the U. K. Medical Center staff.

Kingsley Stevens, M.D., who joined the staff on January 1 after six months as the chief medical resident at St. Joseph Hospital, Lexington, received a three-year $62,000 grant from the National Institute of Health. An assistant professor of medicine, he will study the production of antibodies.

Alfred D. Winer, M.D., an instructor in biochemistry, was the recipient of a five-year $61,570 Senior Resident Fellowship from the United States Public Health Service for the study of enzymes. Doctor Winer currently is studying on a post-doctural fellowship at the Maudsley Hospital, University of London.

Press Honors Dr. Plummer

Dr. Neil Plummer, dean of the School of Journalism at the University of Kentucky, was named Kentucky's Outstanding Journalist of the Year by the Kentucky Press Association at its annual midwinter meeting in January. He is the first recipient of the new award to be given annually to the person contributing most to journalism in the state.

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Further, because of its different site and mode of action in the renal tubules, Aldactone has a true, highly valuable synergistic activity when used with a mercurial or thiazide diuretic.

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When used alone, Aldactone will produce a satisfactory diuresis in about half of those patients whose edema is resistant to conventional diuretic agents.

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DOSAGE: For most adult patients the optimal dosage of Aldactone, brand of spironolactone, is 100 mg. four times daily. Aldactone should be administered for at least four or five days before appraising the initial response, since the onset of therapeutic effect is gradual when it is used alone. Aldactone manifests accelerated activity with greater response as early as the first and second days when used in combination with a mercurial or thiazide diuretic.

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Dr. Abell to Give Program For Eighth District

Irvin Abell, Jr., M.D., Louisville, president of the Kentucky State Medical Association, will give the program for the Eighth Councilor District meeting in Covington on Thursday, April 7. The setting will be the Club House in Devon Park.

Norman Adair, M.D., Covington, councilor of the district, announced that dinner would be served at 6:30 p.m. following a cocktail hour.

The district is composed of Boone, Kenton and Campbell counties.

Districts 9 and 11 Meet Jointly In Paris, April 14

The Ninth and Eleventh Councilor Districts will unite for a meeting at the Tuberculosis Hospital in Paris on Thursday, April 14, with the hospital as host. KSMA President Irvin Abell, Jr., M.D., Louisville, will be the featured speaker.

Announcement of the meeting was made jointly by J. M. Stevenson, M.D., Brooksville, and J. M. Bush, M.D., Mt. Sterling, councilors of the Ninth and Eleventh Districts, respectively. Doctor Bush will preside at the afternoon session and Doctor Stevenson will have charge of the evening session.

The scientific program will be presented by four Louisville physicians. The speakers and their subjects will be: "Psychiatry For the G. P.," Frank M. Gaines, Jr., M.D.; "Changing Status of Pneumonia," Grover G. Sanders, M.D.; "G. I. Surgery," Samuel D. Weakley, Jr., M.D., and "Surgical Diseases of the Chest," Daniel E. Mahaffey, M.D.

The KSMA Committee on Postgraduate Education cooperated in setting up the program for physicians of the 20 counties in the two districts. Included in the Ninth District are Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Robertson and Scott counties. The Eleventh District embraces Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell and Wolfe counties.

14th Councilor District to Meet April 20 At Hazard

The program for the annual meeting of the Fourteenth Councilor District, set for April 20 at Hazard, has been announced by C. C. Rutledge, M.D., Hazard, who is in charge of arrangements.

Three Lexington physicians will present the scientific session, starting at 4 p.m. (CST), as follows: "Management of the Allergic Patient With Emphasis On Asthma," Maurice Kaufmann, M.D.; "Congenital Anomalies Involving the Lower Urinary Tract In Children," E. H. Ray, Jr., M.D. and "Chlorothiazide In the Treatment of Hypertension," Carl H. Fortune, M.D.

William C. Hambley, M.D., Pikeville, councilor of the Fourteenth District, will preside at the dinner meeting, at which KSMA President Irvin Abell, Jr., M.D., Louisville, will speak.

A special program of bridge, golf and horse-back riding or buggy riding is being arranged for wives of the physicians.

The Perry County Medical Society of which A. B. Pigman, M.D., Allock, is president, is host for the meeting.

13th Councilor District Set For Ashland Meeting

Plans are complete for the 13th Councilor District meeting at the Henry Clay Hotel in Ashland on April 21, according to Charles B. Johnson, M.D., Russell, councilor for the district.

Host for the occasion will be the Boyd County Medical Society, of which John Hopkins Neyer, M.D., Ashland, is president.

Three 40-minute papers are scheduled for presentation at the scientific session starting at 2 p.m. Speakers and their subjects include: "Medical Evaluation of the Presurgical Patient," Edmund D. Pellegrino, M.D., professor and chairman of the Department of Medicine, U. K. Medical Center, Lexington; "Common Fungus Infections In Kentucky," Michael Furculow, M.D., chief of the U. S. Public Health Service, Kansas City, Kan.

The social hour at 5:30 p. m. will be followed by a dinner at 6:30 p. m. with KSMA President Irvin Abell, Jr., M. D., Louisville, as featured speaker.

Doctor Neyer will preside at the afternoon session and Doctor Johnson will take charge of the evening program.

Second District to Meet May 31

The Second Councilor District has set May 31 for its meeting in Owensboro, announces Walter L. O'Nan, M.D., Henderson, councilor of the district. The program will be announced in the April issue of the Journal.

Pediatric Society to Convene In Somerset April 6-7

The Kentucky State Pediatric Society will hold its annual meeting on Wednesday and Thursday, April 6 and 7, at the Somerset Country Club, it is announced by Robert N. McLeod, Jr., M.D., Somerset.

The scientific program will open on Wednesday at 4 p.m. (CST), and will be resumed in the evening following a social hour and dinner. A scientific session is also scheduled for Thursday, from 9 a.m. to noon.

Guest speakers will be Sidney Gellis, M.D., chairman of the Department of Pediatrics, Boston University School of Medicine, and Loren McKinney, M.D., assistant professor at the University of North Carolina Medical School, Chapel Hill. The program will also include a panel discussion with four pediatric surgeons in the state participating.

PG Medical Opportunities Listed For Second Quarter

Under a new program initiated by the KSMA Postgraduate Medical Office, a monthly announcement of all postgraduate opportunities offered in Kentucky and adjoining states will be made in the KSMA Journal.

Detailed information on these listings may be obtained through the Postgraduate Medical Office, 104 West Chestnut Street, Louisville 2. The telephone number is JUniper 7-7135.

Following is a listing of the postgraduate opportunities for April, May and June that were available at press time:

April

4-18	"Postgraduate Course In Anatomical and Clinical Otolaryntology," 45th annual meeting; Indiana University School of Medicine, Indianapolis; fee, $250.
5-7	Kentucky Public Health Association meeting; Sheraton Hotel, Louisville.
6-7	Kentucky State Pediatric Society, annual meeting; Somerset Country Club, Somerset; 4 p.m. (CST).
11-15	"Postgraduate Course In Radiology of the Ear, Nose and Throat"; Indiana University School of Medicine, Indianapolis; fee, $25.
12 through May 31	"University of Louisville Pediatric Postgraduate Course"; Children's Hospital, Louisville; 9:30 a.m. to 12:30 p.m. each Tuesday.
14	Joint meeting of the 9th and 11th KSMA Councilor Districts, with scientific program; T. B. Hospital, Paris; 3 p.m.
19	State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.
20	Meeting of the 14th Councilor District, with scientific program; Hazard; 3 p.m.
20-21	"Postgraduate Course In Diagnosis and Treatment of Heart Disease, Including Special Tests"; Indiana University School of Medicine, Indianapolis; fee, $20.

May

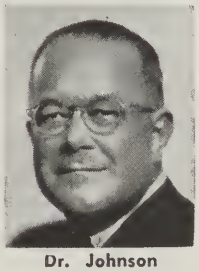
4-6	"Postgraduate Course In Psychiatry for the Family Physician"; University of Tennessee College of Medicine, Memphis.
5	Joint meeting of the 12th and 15th Councilor Districts, with scientific program; Du Pont Lodge, Cumberland Falls; 3 p.m.
9	Kentucky Chapter of the American Academy of Pediatrics, annual meeting; University of Kentucky Medical Center, Lexington.
11-13	Kentucky Academy of General Practice, annual meeting; Kentucky Hotel, Louisville.
12-14	Kentucky Obstetrical and Gynecological Society, annual meeting; Campbell House, Lexington.
17	State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.
18-19	"Postgraduate Course In Diagnosis and Treatment of Common Endocrine Disorders"; Indiana University School of Medicine, Indianapolis; fee, $20.
18-20	"Postgraduate Course In Fractures and Dislocations"; University of Tennessee College of Medicine, Memphis.
25	State Tuberculosis Hospital Chest Group meeting; State Tuberculosis Hospital, District 2, Louisville; 8 p.m.
25-26	"Symposium on Selected Topics In Gastro-Neurology"; University of Kentucky Medical Center, Lexington.

June

9	Joint meeting of the 4th and 6th Councilor Districts, with scientific program; Mammoth Cave Hotel; 3:30 p.m.
14	State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.
17-18	Kentucky and Indiana Chapters of the American College of Surgeons and the Kentucky Society of Anesthesiologists and corresponding anesthesiology organization of Indiana, joint meeting; French Lick, Ind.

Dr. Johnson, Ex-Member of U. L. Medical Faculty, Dies

William Oscar Johnson, M.D., former head of the Department of Obstetrics and Gynecology at the University of Louisville School of Medicine, died on February 5 at his home in Louisville. He was 65.



Dr. Johnson

Under the terms of Doctor Johnson's will, the medical school receives proceeds from insurance policies totaling $23,389.

Doctor Johnson, a native of Winchester, was graduated from Johns Hopkins Medi- School in 1920. He was a resident in the Cleveland Clinic Hospital from 1920 to 1926, then went abroad for a year's postgraduate study, after which he came to the U. of L. School of Medicine as a clinical assistant in gynecology. He became department head in 1947 and resigned the post in 1957.

He was active in organized medicine and as an alumnus of Kentucky Wesleyan College. He was past president of the American Society of Obstetricians and Gynecologists, the Central Association of Obstetricians and Gynecologists, the Southern Gynecological and Obstetrical Society and the Kentucky and Louisville Obstetrical and Gynecological Societies. He was vice-president of KSMA in 1952.

Doctor Johnson was a veteran of World Wars I and II.



Indian articrafts from the collection of Robert W. Lykins, M.D., Louisville, provided a picturesque exhibit at the first annual hobby and talent show put on February 15 by the Jefferson County Medical Society. Doctor Lykins also demonstrated his talents as a musician by playing the drums for the "Jazz Combo" and singing with the barbershop quartet, "The Quackerjacks."



Conversation with other ham radio operators in different parts of the world was carried on at the show by George W. Schafer, M.D., Louisville, by means of equipment he had set up in the exhibit area. On the wall are various licenses and permits he has received for operating his radio equipment.

Jefferson County Society Puts On Hobby and Talent Show

More than 500 physicians and their wives attended the first annual hobby and talent show which was held as the regular meeting of the Jefferson County Medical Society, Monday evening, February 15, at the Brown Hotel in Louisville.

Society President George W. Pedigo, Jr., M.D., said that there were some 60 physicians taking part in the 37 exhibits that filled the South Room and the South Alcove at the Brown. The exhibits included everything from camellias to cats and model railroads to fancy wood finishings.

Following the hobby show and dinner, the talent show was presented as a conclusion to the five-hour get-together. The length and vigor of the applause which greeted the presentation of each of the talent-show numbers was conclusive evidence of the manner in which the program was received.

President Pedigo gave full credit to Orson P. Smith, Jr., M.D., for fathering and developing the idea. He also had high praise for all who cooperated in making the program successful.

A standing ovation was given to retiring president, Foster Coleman, M.D., following a tribute paid him by another past president of the society, Sam A. Overstreet, M.D.

Immunization Week In Kentucky Set For May 1-7

In observance of National Child Health Month, the first full week in May has been set aside as "Immunization Week In Kentucky." This seventh annual event is under the sponsorship of the KSMA and other state-wide organizations, according to Delmas Clardy, M.D., Hopkinsville, chairman of the KSMA Committee on Public Health.

This year's drive for complete immunization in Kentucky will be promoted through newspapers, radio, television and other media. Special emphasis during the May 1-7 period will be placed on vaccines for polio, diphtheria, pertussis, tetanus, smallpox and other communicable diseases.

Immunization Week will be featured during May meetings of Homemakers Clubs, the KSMA Woman's Auxiliary, Federated Women's Clubs and other groups.

April 1 Is Deadline For Dues, Members Are Reminded

Members who have not paid their 1960 dues have less than a month to do so, KSMA President Irvin Abell, Jr., M.D., Louisville, has pointed out. The deadline, as provided by the KSMA Bylaws, is April 1.

Doctor Abell expressed appreciation to the members who have already sent their remittances for county, state and AMA dues to the Headquarters Office of KSMA. "The early cooperation of all others will be appreciated," he said.

He cited Section 2 of Chapter IX of the Bylaws, which reads: "Any county society which fails to pay its assessments, or make the report required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met."

Dr. Fortune Reappointed

Carl H. Fortune, M.D., Lexington, has been reappointed by Gov. Bert Combs to his second term as a member of the State Board of Health. Doctor Fortune's name was one of three submitted to the Governor by the Council of KSMA.

Kentucky Dental Centennial Meeting Opens March 30

The Kentucky Dental Association, marking 100 years of organized dentistry in the state, has scheduled its centennial convention in Lexington, March 30 to April 2, according to Lyman E. Wagers, D.M.D., Lexington, president.



Dr. Wagers

"The Kentucky State Medical Association congratulates the Kentucky Dental Association on 100 years of service to the people of Kentucky," said Irvin Abell, Jr., M.D., Louisville, president of KSMA. "We extend our best wishes for the continued success of this excellent organization."

Dr. A. B. Coxwell, Louisville, secretary of the KDA, and his staff are carrying out final preparations for the centennial. Guest speakers at the convention will include Governor Bert Combs and Dr. Harold Hillenbrand, secretary of the American Dental Association. An inaugural ball is planned as the closing feature.

Meeting in conjunction with the KDA will be the Kentucky Dental Hygienist Association, the Kentucky Dental Assistants Association and the Women's Auxliliary to the Kentucky Dental Association.

AMA Releases Film Made At Dallas Meeting

Highlights of the 13th Clinical Meeting of the American Medical Association in Dallas, December 1-4, 1959, were preserved on 16mm sound film which is now being made available for showing by medical county societies and hospital staffs.

Important scientific developments and selected lectures, exhibits and discussions are included in the 25-minute motion picture. Dr. Oscar Auerbach is seen during an interview on his widely discussed study linking smoking and lung cancer. Dr. Hubertus Strughold gives his views on medicine and man in space.

For the physician who attended the meeting, the film gives an overall view of the happenings, says Carl A. Lincke, M.D., Carrollton, Ohio, chairman of the Council on Scientific Assembly. For those who were unable to attend, the picture offers a way of bringing the meeting to them in capsule form.

Dr. Pronko Honored By Jaycees

Robert Carrington Pronko, M.D., Pineville, was named one of four outstanding young men of Kentucky for 1959 by the Kentucky Junior Chamber of Commerce. The group was honored at a banquet at the Elizabethtown Country Club on January 23.

Doctor Pronko, who began his career as a medical missionary in Puerto Rico, moved to Pineville in 1956. He now has offices both in Pineville and Middlesboro. He is active in organized medicine, the Pineville Jaycees and the Pine Mountain State Park Development Commission. He was cochairman of the 1959 summer production, "The Book of Job," an outdoor religious drama put on to promote tourist trade in his area.

Dr. Wallin Memorial Group Formed At Brooksville

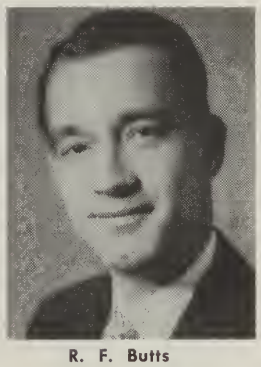
The Dr. W. B. Wallin Memorial Association has been formed at Brooksville in honor of the Bracken county physician who died last December 15. The group voted to ask for voluntary contributions to provide a memorial.

J. M. Stevenson, M.D., Brooksville, councilor for the Ninth District, was elected chairman of the committee to decide on the kind of memorial to be erected.

Doctor Wallin was the 1954 winner of the KSMA Outstanding General Practitioner Award.

SMA Business Manager Named To Executive Post

Robert F. Butts, Birmingham, business manager of the Southern Medical Association, has been named executive secretary-treasurer of the 14,000-member organization. He retains his duties as business manager.



R. F. Butts

The announcement was made by SMA president, Edwin Hugh Lawson, M.D., New Orleans, who also announced the appointment of V. O. Foster, Birmingham, as public relations counselor. C. P. Loranz, Birmingham, keeps his office of advisor and special consultant.

Mr. Butts, a 1947 graduate of the University of Alabama, received a degree in trade association management at Northwestern University. Since going to SMA in January, 1948, he has held the offices of assistant to secretary-manager, assistant secretary-manager, business manager and associate executive secretary-treasurer.

Two Louisville physicians hold offices in SMA. A. Clayton McCarty, M.D., is the 1960 vice-president and J. Duffy Hancock, M.D., is the Councilor from Kentucky.

Dr. Denham Speaks In Murray

"New Approaches to Old Cardiac Problems" was the subject discussed by Ralph M. Denham, M.D., Louisville, before the membership of the Calloway County Medical Society in Murray on February 11, according to Hugh L. Houston, M.D., secretary. A round table discussion followed the talk.

While in Murray, Doctor Denham also addressed the Rotary Club on the subject, "The Coronary Club," and spoke to a group of nurses on "Management of the Severely Ill Coronary Patient."

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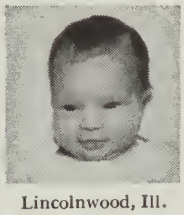
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NEWS ITEMS

Leland Campbell Brown, M.D., who had been practicing medicine at Wheelwright, has moved to Owenton. According to a newspaper report, he has reopened the office of Maurice Bowling, M.D., who has been ill since last summer. A native of Lexington, Doctor Brown received his medical degree from Northwestern University in 1954. He practiced at Martin for 18 months, after which he served in the U. S. Navy for two years. He located at Wheelwright in February, 1959.

Walter A. Cole, Jr., M.D., has started practice in Brandenburg in association with R. O. Naser, M.D. Previously located at Radcliffe, he opened offices in Hardinsburg for a short time before going to Brandenburg. Doctor Cole, a native of Kentucky, was graduated from the University of Louisville School of Medicine in 1956 and served his internship in Jacksonville, Fla. He was in the U. S. Air Force for two years, attaining the rank of captain.

Paul E. Davis, M.D., has opened an office in the Katterjohn Building, Paducah, for the practice of psychiatry. He formerly was chief of the outpatient department at Western State Hospital, Hopkinsville. A native of Paducah, Doctor Davis received his M.D. degree from the University of Louisville School of Medicine in 1952. He interned at Veterans Hospital, Long Beach, Calif., and held two residencies at Central State Hospital, Norman, Okla. He served from 1942-1945 as a corporal in the U.S.M.C.

Robert J. Ertel, M.D., Covington, and **James A. Ryan, M.D.,** Fort Mitchell, were honored early in the year by the Campbell-Kenton County Medical Society for a half century of service as physicians. Also cited posthumously was the late **Philip Dorger, M.D.,** who died last September. His honor was accepted by his son, John Dorger, M.D., Covington.

Ollie B. Emerine, M.D., has started the practice of medicine in Elizabethtown, in association with John C. Bates, M.D. A native of Carresville, Doctor Emerine was graduated from the University of Louisville School of Medicine in 1956. After a year's internship at the U. S. Naval Hospital, Portsmouth, Va., he served a six-month residency at the U. S. Naval School of Aviation Medicine, Pensacola, Fla., and was designated a Naval Flight Surgeon in December, 1957.

Thomas K. Hepler, M.D., a Pennsylvanian, has been appointed to the newly-created posts of pathologist and laboratory director at Jennie Stuart Memorial Hospital, Hopkinsville. He will also practice at Memorial Hospital, Clarksville, Tenn., where he is making his home. Since 1950, Doctor Hepler has been associated with Geisinger Memorial Hospital, Danville, Pa., where he interned and took residency training. He also held a three-year residency at Mayo Clinic, Rochester, Minn. A 1941 graduate of Jefferson Medical College, he was in the Air Forces for four years, with the rank of major.

A. M. Lyon, M.D., Frankfort, superintendent of Kentucky Training Home, has been named health officer for Boyd county, effective March 1. Doctor Lyon is a former director of Western and Central State Hospitals, a former commissioner of welfare, and former health officer for Lawrence county.

Willard F. Chumley, M.D., who was associated with Oscar Allen, M.D., in the practice of medicine at Beaver Dam, left January 9 for Camp LeJeune, North Carolina, where he will be stationed with the U. S. Navy, attached to the Second Marine Division, Fleet Marine Force. He holds the rank of lieutenant, second grade. Doctor Chumley was a member of the Ohio County Hospital medical staff.

H. G. Sargent, M.D., physician at Barlow for the past 12 years, has been appointed health officer for McCracken and Ballard counties. He will serve as director of the Paducah-McCracken County Clinic, succeeding Norman Parrott, M.D., who has accepted the post of health officer for Lyon, Livingston, Calloway and Marshall counties. Doctor Sargent, a native of Ballard, is a 1946 graduate of the University of Louisville School of Medicine.

James E. Ross, M.D., has opened an office in Lexington to practice general surgery. A native of Lexington, Doctor Ross was graduated from the University of Louisville School of Medicine in 1954. He interned at Louisville General Hospital, where he also had a residency from 1955-59. He served two years in the Air Corps of the U. S. Navy.

Forest F. Shely, M.D., Louisa, was named "Man of the Year" by the Louisa Chapter, American Businessmen's Club, at a testimonial dinner in December, honoring him as a physician and civic leader. At 35, Doctor Shely is a trustee of Campbellsville College, city councilman, member of the Lawrence County library board, church choir director and Sunday-school superintendent, president of the Toastmasters Club, and immediate past president of the Rotary Club. He is a graduate of the University of Louisville School of Medicine.

George T. Tootell, M.D., a surgeon in China for many years, has opened an office in Pine Mountain for the general practice of medicine. A native of Chicago, Doctor Tootell received his medical degree from Loyola Medical College in 1912 and served his internship in Chicago hospitals. He was in Red Cross service during both World Wars, and was a civilian medical officer at Camp Stoneman in California, 1950-53. He later practiced in Moon Valley, N. M.

Thomas S. Wallace, Jr., M.D., who formerly was associated with George S. Allen, M.D., in the practice of medicine in Louisville, is the new TB control officer of the Louisville-Jefferson County Health Department. Doctor Wallace, a native of Louisville, was graduated from the University of Louisville School of Medicine in 1951 and interned at St. Joseph Infirmary. He served in the Infantry of the U. S. Army from 1941 to 1946, with the rank of captain.

Committee Reports

Committee to Study New Home

George F. Brockman, M.D., Chairman

The House of Delegates, at its September 23, 1959, meeting authorized the Council of KSMA to appoint a committee to study the possibility of building a new home for the KSMA Headquarters Office. The action also specified that the committee should visit surrounding state medical associations that have erected such buildings.

This committee met in December, viewed the crowded conditions at the Headquarters Office, inspected blueprints from seven state medical associations that had recently built offices and comments made by these states. It also planned a visit to three neighboring states as provided in the House of Delegates instructions.

After visiting the neighboring states, the committee met again on February 11. The information derived from the visit to other states was carefully reviewed. It was agreed that the committee would meet again, following additional study, before drafting its report to the House of Delegates in September, 1960.

Committee on Postgraduate Medical Education

Walter S. Coe, M.D., Chairman

Louisville **January 13, 1960**

Friedrich Hertle, newly-appointed executive director of the Postgraduate Medical Education Office, was introduced to those present. The address of this office will be 104 West Chestnut Street, Louisville.

The contract of agreement, whereby the KSMA Postgraduate Fund Office accepted the $10,000 appropriation from the Kentucky State Medical Association, was officially sanctioned by the committee.

Reports were given by the various representatives as to their plans for postgraduate programs in Kentucky for the coming year. This is one of the long-range planning goals of this new office.

Plans were also formulated for a postgraduate program in Lexington some time in May, 1960. The date of this day-and-a-half meeting will be announced later, along with the program.

Advisory Committee to Journal Editor

James E. Hix, M.D., Chairman

Louisville **January 21, 1960**

Selection of eight new members of the Board of Consultants on Scientific Articles and appointment of a Special Symposium Editor for 1960 were among the items on the agenda of the January 21 meeting of the Advisory Committee to the Editor of the Journal of KSMA.

Named Symposium Editor is Edmund D. Pellegrino, M.D., Lexington, professor and chairman of the Department of Medicine, University of Kentucky Medical Center. Wallace E. Herrell, M.D., Lexington, who edited the Symposium Issue the past two years, asked to be relieved.

The committee authorized a new feature for the Journal—a Tax Page to be published quarterly. The articles will be written by William E. Rudd, KSMA executive assistant, who has had previous experience as an accountant for the Internal Revenue Service.

Plans were discussed for the Southeastern States Medical Editors Conference to be held in Lexington, October 15-16, with KSMA as host. It was announced that Lexington was chosen as the site to give visiting editors an opportunity (1) to visit the University of Kentucky's new College of Medicine; (2) to attend the University of Kentucky-Louisiana State University football game, and (3) to tour Kentucky's Bluegrass Section at one of the most beautiful seasons of the year.

The committee also decided to delete from the Annual Meeting Issue of the Journal, effective in 1961, the insert-photograph of the incoming KSMA president. The practice was abandoned because there appeared to be no demand for the page, and it was pointed out that the insert actually was a duplication inasmuch as a large picture of the retiring president is carried each year.

KSMA Advisory Committee on Public Health

Delmas Clardy, M.D., Chairman

Louisville **January 21, 1960**

The KSMA Advisory Committee on Public Health at this meeting reviewed its recommendations of 1959 that were submitted to the KSMA Council and the 1959 House of Delegates session.

"Immunization Week," one of the yearly functions of this committee, was set for the first week in May —May 1-7.

The committee also heard Russell Teague, M.D., State Commissioner of Health, and Delmas Clardy, M.D., chairman of the committee, give reports on vaccination programs, automobile accidents, cancer of the cervix, cancer of the lung and fluoridation in Kentucky.

U. L. Medical School Gets Grants For Pathology Project

About $150,000 in grants from the National Institutes of Health will enable the University of Louisville School of Medicine to inaugurate a postdocturate training program in pathology about July 1.

This was made known in February following announcement of the first of five $30,015 annual grants by the U. S. Public Health Service research center at Bethesda, M.D.

William M. Christopherson, M.D., professor and chairman of the Department of Pathology, and Hubert C. Pirkle, M.D., assistant professor of pathology, will be codirectors of the program.

$7,500 Given For Eye Research

Receipt of another grant — $7,500 for eye research — has been announced by the U. of L. School of Medicine. The grant brings to $32,500 the total of research aid sent to Kentucky by the Knights Templar Eye Foundation, Inc.



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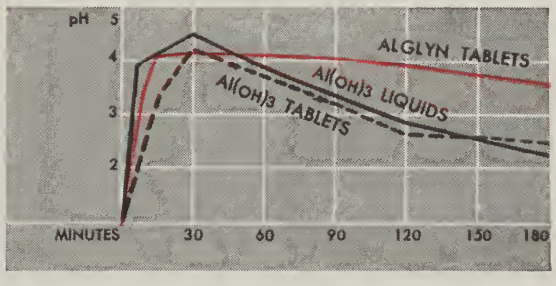
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Student AMA

Medical school faculties throughout this country are becoming more and more reluctant to permit their students to extern in non-teaching institutions. Several of the eastern medical centers do not allow extracurricular externships.

The University of Louisville Medical School has adopted a somewhat liberal but firm attitude on this point. Its policy asks that each student desiring to work while attending medical school notify the dean's office; permission is refused those on probation or others the faculty feels could not do proper justice to their schooling.

Externships are set up for the benefit of the hospitals and, in a roundabout way, for the doctors of that hospital. Histories and physicals, handling the emergency room, giving intravenous medications, checking in patients whose conditions warrant immediate attention, calming nurses, and often assisting in OB cases are the more routine tasks expected of an extern.

Medical faculties are opposed to externships for several reasons. The primary objection seems to be that we, as students, do not know what is the right or the wrong manner with which to handle most medical situations; the teaching institutions teach the most recently accepted way, whereas externs are often taught improperly in private hospitals. Is this really bad?

When a student begins to externe, he is usually in his junior or senior year; he supposedly has some judgment or else he would never have come that far. The extern should be wise enough to question the processes he does or witnesses if the results are not gratifying. The extern can refuse to handle any situation that may arise of which he does not believe himself capable.

Another argument which seems quite valid against externships is that the time could be used for study. No one can deny that reading is the most reasonable approach to learning; however, I know of few medical students who study at every opportunity.

The writer endorses medical students externing in their clinical years, unless plagued by scholastic difficulties. An externship gives the student several important attributes which one can never hope to absorb in medical school. Learning to approach private patients, seeing medicine as it actually is practiced, obtaining ideas of right and wrong, and participating in medical problems are but a few of the attributes to be gleaned from an externship.

A prudent student who uses his brains as well as his brawn in an externship will be a better physician. If he honestly considers his own limitations and the patient's welfare, he can not go too far wrong.

Robert V. McKechnie
President, U. of L. Chapter
Student AMA

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County Society Reports

Bourbon County

New officers of the Bourbon County Medical Society are: President, William W. Dye, M.D.; vice-president, William H. Cox, M.D.; secretary-treasurer, Thomas G. Perkins, M.D. Selected as delegate and alternate delegate to the 1960 Annual Meeting of the KSMA were Richard J. Wever, M.D., and Erwin Asriel, M.D. All are Paris physicians.

Graves County

Thomas B. Stone, M.D., Mayfield, is the new president of the Graves County Medical Society. Other officers elected at the group's annual meeting were A. Reeves Morgan, M.D., vice-president, and H. H. Roach, M.D., member of the board of censors.

Richard L. Colley, M.D., and William F. Ruoff, M.D., were named delegate and alternate delegate, respectively, to the 1960 Annual Meeting of the Kentucky State Medical Association.

Harlan County

The Harlan County Medical Society, acting on a report by its pre-medical student committee that the county has 19 prospective physicians among high-school seniors and college students, made plans at its January meeting to give them all possible encouragement. The students will be invited, four at a time, to attend meetings of the society, and each will be presented a description of the W. Clark Bailey Memorial Fund.

The society voted to accept recommendations of the legislative committee that the organization go on record as favoring legislation related to the diagnosis and treatment of cancer by physicians, osteopaths and dentists only; an act relating to deaths and disposal of dead bodies, known as the Anti-Quick Cremation Bill, and the act relating to medical care of indigent persons.

Guest speaker at the meeting was Douglas M. Haynes, M.D., professor and chairman of the Department of Obstetrics and Gynecology at the University of Louisville School of Medicine. His subject was "Fetal Respiration."

McCracken County

Many requests are being made of the Health Department for all types of examinations for food handlers, the society's health clinic committee reported at the January meeting. It was stressed that the examining physician should feel free to ask for any of these tests but he should not overlook the fact that, in determining the applicant's health, he should request only the tests that are necessary to aid in the thorough physical exam.

The legislative committee reported that the members should be aware of what bills are being presented in the State Legislature and be ready at any time to wire their Representatives and express their views on proposed legislation. The committee stated it would keep the society posted on the appropriate time for specific backing to be made.

The secretary, Glenn R. Noss, M.D., asked the members to note on supplied forms the type of specialty journal they wished to receive with their AMA Journal and return the forms with their remittances for dues.

The scientific session was presented by A. G. Kammer, M.D., head of the Department of Occupational Medicine at the University of Pittsburgh. He spoke on "Industrial Medicine As a Science of Prevention."

Johnson County

James W. Archer, M.D., was elected 1960 president of the Johnson County Medical Society and its delegate to the Annual Meeting of the Kentucky State Medical Association. Other officers named were: Vice-president, A. B. Carter, M.D., and secretary-treasurer, Maurice M. Hall, M.D. Paul B. Hall, M.D., was chosen alternate delegate to KSMA.

Pike County

The Pike County Medical Society has announced the election of the following officers for 1960: President, W. C. Hambley, M.D., Pikeville; vice-president, Roy Sanders, M.D., Dorton; secretary-treasurer, Edward I. Rustin, M.D., Pikeville.

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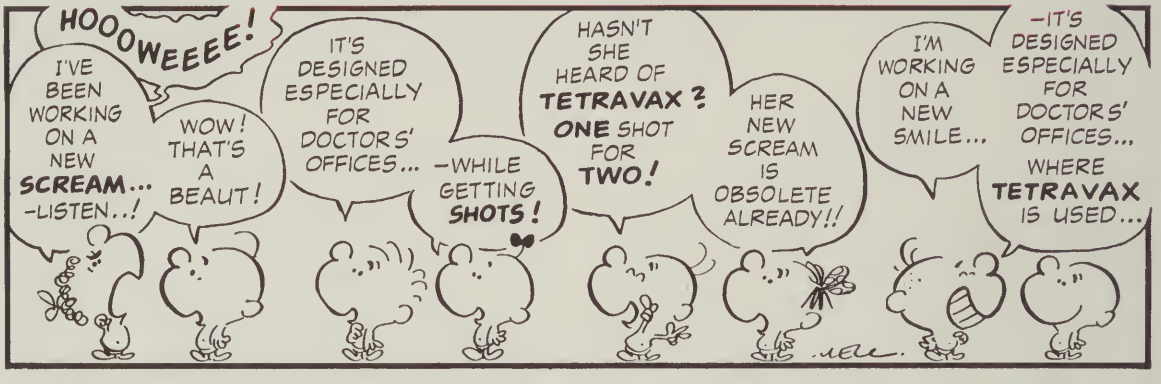
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In Memoriam

L. F. BEETEM, M.D.
Bedford
1902-1960

Luther Franklin Beetem, M.D., 58, who formerly practiced at Bedford and Milton, died on January 26 at St. Joseph Hospital, Louisville. Death was attributed to a heart attack.

Born in English, Ky., Doctor Beetem received his M.D. degree from the University of Cincinnati College of Medicine in 1929 and took graduate training in eye, ear, nose and throat medicine at Washington University, St. Louis. He left Kentucky in 1938 to practice in Madison, Ind. He was a major in the Medical Corps during World War II.

ARTHUR O. GOODMAN, M.D.
Louisville
1889 - 1960

Arthur Ouchterlony Goodman, M.D., who at 70 was still active as a practicing physician, died of a heart attack at Jewish Hospital, Louisville, on January 16. He was named Family Doctor of the Year in 1956 by the Kentucky Academy of General Practice.

A native of Louisville, Doctor Goodman was graduated in 1915 from the Medical Department of the University of Louisville, where he later taught. He began practice in the Cabbage Patch area of Louisville. During World War I he served two years in the U. S. Army Medical Corps. He was president of the Jefferson County Academy of General Practice in 1959.

EDWARD HERMANN, M.D.
Newport
1879 - 1959

Edward Hermann, M.D., practicing physician in Newport for some 55 years, died in December. He was 80 years old.

Doctor Hermann, a 1903 graduate of Miami Medical College, was a member of a medical family. His brother, the late George J. Hermann, M.D., was a physician, as are his two nephews, James Schroer, M.D., Newport, and George Hermann, M.D., Fort Thomas.

J. A. C. LATTIMORE, M.D.
Louisville
1875 - 1959

John A. C. Lattimore, M.D., physician in Louisville for more than 50 years, died on December 31 at his home after a long illness. He was 84.

Doctor Lattimore, one of the first Negro members of KSMA, was a 1901 graduate of the Meharry Medical School, Nashville. He was active in the Urban League and was a member of its board of directors until his death.

LINDSAY MORRISON, M.D.
West Point
1870-1960

Lindsay Morrison, M.D., who started practicing medicine in Kentucky at the turn of the century, died in Indiana early in the year, according to word received at West Point, his former home. He was 90.

A native of the state, Doctor Morrison was graduated from the old Hospital College of Medicine, Louisville, in 1900. He practiced in Lebanon, West Point, Frankfort and Louisville before going to Hammond, Ind., in 1922. He was founder and first editor of the old West Point Beacon and served as postmaster at West Point for a number of years.

JOHN C. ROGERS, M.D.
Henderson
1896-1960

John C. Rogers, M.D., a practicing physician in Henderson for almost 30 years, died on January 31 at his home there at the age of 64. He retired from active practice last July to become health officer for Henderson, Union and Webster counties.

Born in Henderson, Doctor Rogers started his career as a high-school teacher before taking up the study of medicine. He received his M.D. degree from Rush Medical College in 1931. During World War I he served in the U. S. Navy.

Government Relations Expert Senior Day Speaker

Lester H. Means, Washington, D.C., government relations director for the General Electric Company, will be the featured speaker at the joint KSMA Senior Day—Jefferson County Medical Society dinner on Monday, May 16. Mr. Means lived in Louisville for a number of years before his recent transfer to Washington.

N. L. Bosworth, M.D., Lexington, chairman of the Special KSMA Senior Day Committee, and George W. Pedigo, Jr., M.D., Louisville, president of the Jefferson County Medical Society, made the announcement of the speaker's acceptance of their invitation. This is the sixth annual Senior Day sponsored by the KSMA for senior medical students at the University of Louisville School of Medicine.

KSMA President Irvin Abell, Jr., M.D., Louisville, will open the program with an address at noon in the Rankin Amphitheater of Louisville General Hospital.

A round of talks by well known Kentucky physicians is scheduled for the afternoon session, starting at 3 o'clock at the Brown Hotel. The social hour and dinner in the Brown Roof Garden will close the day's activities.

Senior Day is aimed at giving the future medical graduate an insight into actual practice. Cooperating with KSMA in its sponsorship are the University of Louisville School of Medicine and the Jefferson County Medical Society.

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Committee on Scientific Exhibits

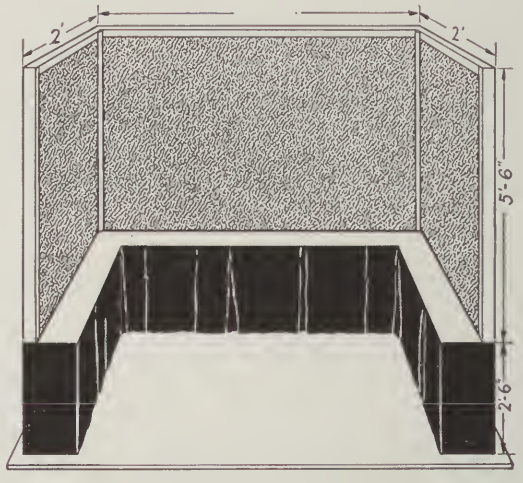
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6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

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1. Projection from Vital Statistics, U.S. Government Dept. HEW, Vol. 48, No. 14, 1958, p. 398.
2. Modell, W.: Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.

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KIMA Schedules Clinical Meeting In Lexington April 7

The Kentucky Industrial Medical Association invites all persons interested in industrial medicine and surgery to a clinical meeting at the International Business Machine Plant, Lexington, on Thursday, April 7. A plant tour at 2:30 p.m. will precede the clinical program at 4 p.m., announces Eugene H. Kremer, Jr., M.D., Louisville.

Two Cincinnati physicians will conduct the afternoon clinical session. Ray Suskind, M.D., of Kettering Laboratory, will speak on "Industrial Dermatology" and H. W. Lawrence, M.D., of Proctor & Gamble Company, will discuss "Practical Environmental Control of Industrial Dermatitis."

D. John Lauer, M.D., of Jones and Laughlin Steel Corporation, Pittsburgh, will be the dinner speaker. He will be introduced by Gradie Rowntree, M.D., Louisville. A. A. McLean, M.D., of IBM Corporation, New York, will address the evening session, speaking on "Mental Health In Industry."

KPHA to Meet April 5-7 In Louisville

The Kentucky Public Health Association has announced its 1960 annual meeting for April 5, 6 and 7 at the Sheraton Hotel in Louisville.

KSMA President Irvin Abell, Jr., M.D., Louisville, who is a member of KPHA, urges all members of KSMA to support this organization and attend the meeting if at all possible.

Pan American Congress Set

The Pan American Medical Women's Alliance will hold its Seventh Congress in San Juan, Puerto Rico, June 3-8, according to a release received by Helen B. Fraser, M.D., M. P. H., director of Kentucky's Bureau of Maternal & Child Health. The program chairman is Dr. Cornelia Carithers of Jacksonville, Fla.

Applicants for membership to the Alliance should be made to the treasurer, Dr. Eva Cutright, 458 Beall Avenue, Wooster, Ohio. The fee is $4 for the biennium 1959-60. Other inquiries may be addressed to the PAMWA publicity chairman, Hilla Sheriff, M.D., Division of Maternal and Child Health, S. C. State Board of Health, Columbia 1, S. C.

Dr. North to Be ACS Director

John Paul North, M.D., well-known surgeon and educator of Dallas, Texas, will become the Director of the American College of Surgeons on January 31, 1961, it has been announced by I. S. Ravdin, M.D., Chicago, chairman of the College's Board of Regents. He will succeed Paul R. Hawley, M.D., Director since March, 1950.

Doctor North has been chief of surgical service at Veterans Hospital, Dallas, since 1955 and professor of clinical surgery at Southwestern Medical School of the University of Texas since 1946. During World War II, he received the Legion of Merit for outstanding service in the C.B.I. Theater. Widely known for his contributions in the field of trauma, Doctor North has contributed articles on this and other subjects of surgical interest to notable scientific journals.

Fewer Mental Patients In State

The number of patients in Kentucky's four mental hospitals at the end of the last fiscal year was down 2.5 per cent from the year before, according to the annual report of Commissioner of Mental Health H. L. McPheeters to Governor A. B. Chandler.

Last June 30, there were 6,914 patients in the hospitals compared to 7,091 at the same time the previous year, the report showed. The decrease was recorded despite a 12.7 per cent increase in admissions during the fiscal year beginning July 1, 1958.

Two refresher courses, "Pediatric Advances" and "Practical Pediatric Hematology," are announced for early June by the Children's Hospital of Philadelphia and the Graduate School of Medicine, University of Pennsylvania. The course, "Pediatric Advances," scheduled for May 30 through June 3, will be conducted by the staff of the Children's Hospital. The other course, set for June 6-10, will be conducted by Irving J. Wolman, M.D.; Thomas R. Boggs, Jr., M.D., and other members of the hematology department of the hospital.

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SPECIAL ARTICLE

(Continued from Page 348)

room, delivery room or emergency room for long periods of time.

To evaluate the adequacy of the nursing service, the Commission requests the hospital to submit the ratios of the number of nurses to patients and the number of supervisors to patients. These ratios in themselves are not definitive measurements, and the Commission has no yardstick as to what they should be. However, they do indicate the availability of nursing service. In a hospital with acutely ill patients, the ratio of nurses to patients is expected to be higher than in a tuberculosis sanitarium where no surgery is done. The ratio of supervisors to patients is expected to be higher in those hospitals using a large number of auxiliary personnel. This situation would pertain in minimal care units or convalescent and chronic disease hospitals.

Because adequate supervision is essential to insure safe care, the ratio of nurses to auxiliary workers is given careful attention. By comparing this ratio to the ratio of nurses to patients, the extent to which nurses have the opportunity to give adequate supervision to auxiliary personnel is revealed. It may indicate that the graduate nurse is spread too thinly and is responsible for too many workers to assure safe care.

Good organization is basic to effective group performance and the nursing service, like that of the medical staff, must be organized to carry out its responsibilities. There should be a departmental plan of administrative authority with a definite outline of responsibilities and duties for each category of the nursing staff. There should be personnel records on file, including application forms and verification of credentials. The pattern of organization varies with the size of the staff. The minimum requirements are a Director of the Nursing Service, assistants to the Director for evening and night services, department or floor supervisors, and an adequate number of professional and ancillary personnel for bedside care.

Although no specific structure of committees or departmental organization is suggested, the Commission does require that the nursing staff have regularly scheduled meetings on a monthly basis. These should be formalized and minutes kept. The purpose of staff meetings is to review and evaluate nursing care, with thought given to improving service to patients. To illustrate, nursing staff meetings may appropriately include such topics as nursing care plans for individual patients in the hospital, consideration of specific nursing techniques, establishment and interpretation of nursing department policies, interpretation of administrative and medical staff policies, reports of meetings and conventions and the like.

The organization of the nursing department should permit close working relationships with other services of the hospital, both administrative and professional. Perhaps no department in the hospital is more costly or has closer relationship with the patient than the nursing department, and well defined working relationships with other departments is essential.

The Commission has no requirements as to the distribution or assignment of nurses except that nurses assigned to care for obstetrical patients and the newborn nurseries must not have other duties which may create risk of infection being carried to these patients.

It is expected that there be written nursing-care plans for patients. These may be on the basis of individual patients or a group of patients. The principle is that thoughtful planning has been done to make sure that the patient receives the nursing care he needs.

AMEF Receipts Break Record

The American Medical Education Foundation received $1,181,500 from its 1959 contributions, according to a bulletin released on January 21 by Jay B. Oliver, associate executive secretary. The total, the largest in the Foundation's history, represents an increase of approximately 10 per cent over the previous year and 25 per cent over 1957.

The Foundation was put "on its own" without an AMA grant in 1959. However, all expenses were paid by AMA, with the result that every dollar contributed goes directly to the schools, the bulletin stated.

Frederick Parker Shepherd, M.D., a native of New Jersey, is the new medical director for E. I. duPont de Nemours & Company, Louisville Works. He previously was in private practice at Queenstown, Md., from 1951-1953, and was plant physician with duPont at Savannah River Plant, an Atomic Energy Commission installation near Aiken, S. C., from 1953-1959. Doctor Shepherd received his medical degree from the University of Maryland in 1950 and interned at the U. S. Public Health Service Hospital, Baltimore, Md. He spent three years, 1942-1945, as a first lieutenant in Anti-Aircraft Artillery with the 2nd Armored Division, E. T. O.

A. C. Rolen, M.D., has been called into active duty by the U. S. Naval Reserve from his practice at Butterworth Clinic, Murray. He will be stationed at San Diego. Doctor Rolen plans to return to his practice in Murray after his service with the Navy.

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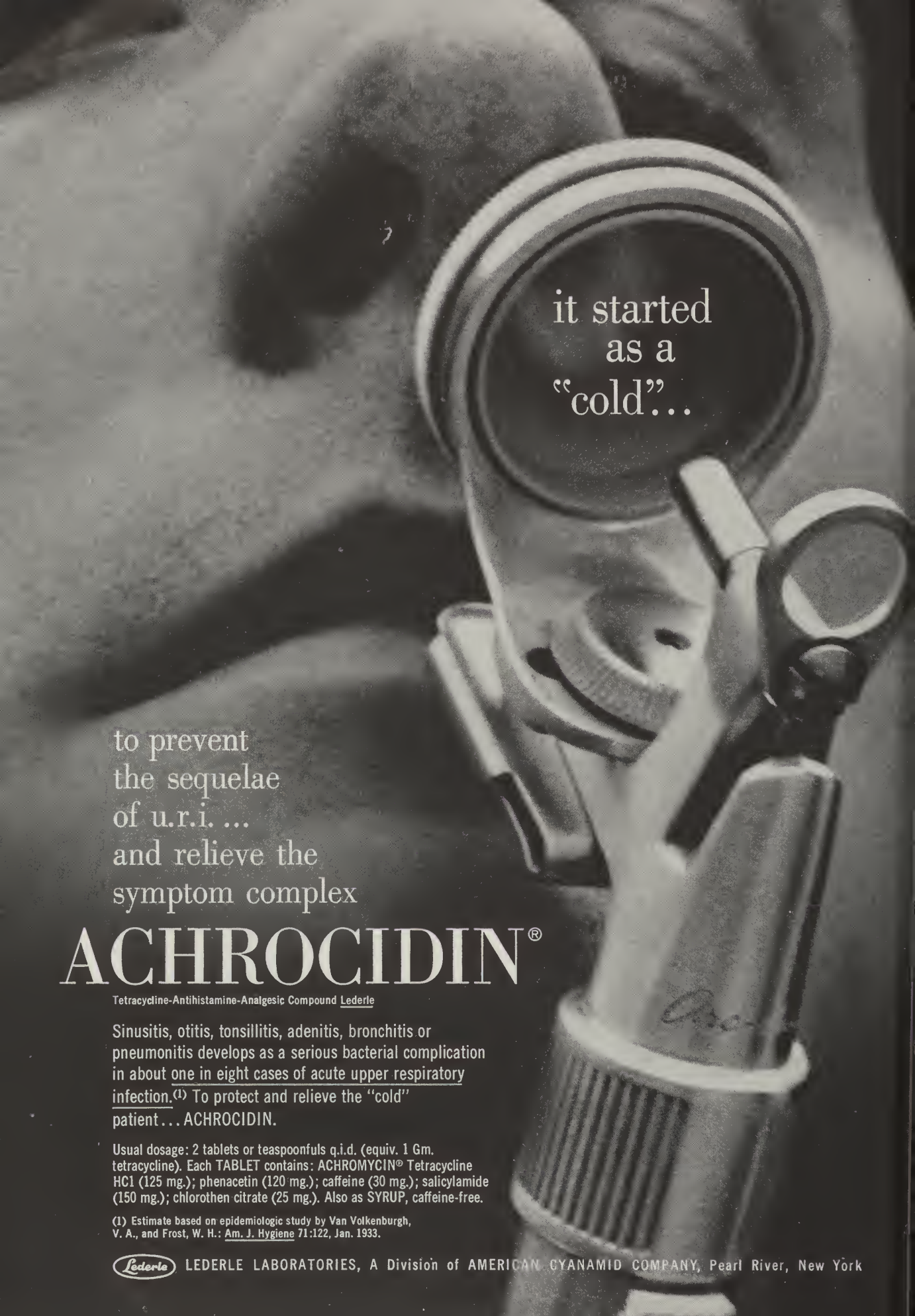
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(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122, Jan. 1933.

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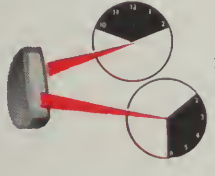
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1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

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IN THE BOOKS



BIOPSY MANUAL: by James D. Hardy, M.D.; James C. Griffin, Jr., M.D., and Jorge A. Rodriguez, M.D.; published by W. B. Saunders Company, Philadelphia and London; 150 pages; price, $6.50.

The authors have performed a needed task in writing this manual; biopsy is the key to the treatment of tumors and many other diseases. It deserves a book of its own.

The first chapter, "General Considerations," is excellent, containing a useful review of the reactions to local anesthetic agents and their remedies. There is a proper emphasis, to our mind, on the point that an excess volume of various local anesthetic agents causes most reactions.

Illustrations of the most common techniques of biopsy in various regions are well chosen and beautifully clear. The sections on breast, chest, liver, stomach, pancreas and the utero-vaginal tract are particularly complete. Somewhat less detailed and less helpful are the sections on the neck, mouth, sinuses and throat. Procedures in making a proper diagnosis of a thyroid nodule are well outlined.

Nearly all of the biopsy procedures in the manual are hospital procedures, with no emphasis on what may be done in the practitioner's office. Furthermore, the authors omit to mention the Tischler biting forceps for cervical biopsy, an instrument with many other uses as well.

Aspiration biopsy to confirm a clinical impression of cancer in large breast and neck masses is not mentioned. However, the use of Silverman's needle for biopsy of the liver, certain lung tumors, pancreas and prostate is described in detail.

While the authors show a competent awareness of the pathologist's desires and problems in regard to biopsy, we feel the manual would be more complete if a pathologist had collaborated and commented on each section.

Condict Moore, M.D.

THE MODERN FAMILY HEALTH GUIDE: edited by Morris Fishbein, M.D.; published by Doubleday and Company, Inc., Garden City, N. Y.; 1,001 pages; price, $7.50.

By his second edition of "The Modern Family Health Guide," Dr. Morris Fishbein adds a valuable asset to any family library.

Written in lay language by 27 noted specialists, each contributing articles in his field, his book covers quite satisfactorily the information on the usual conditions and diseases of the body from infancy to the care of the aged.

The book is divided into 10 parts. The first part which deals with physiology—"The Body and How It Functions," "The Meaning of Health" as well as "You and Your Doctors"—is most interesting. This embraces, in narrative form, yet in brief summary, numerous aspects of life and living as it pertains to medicine; an unusually fascinating episode, indeed. The remaining parts are devoted to authentic elaborations of the fundamentals of specific illnesses.

Difficult subjects, as disorders of the endocrine glands and such, are most lucidly outlined and in sufficient expanse that the acquaintanceship of them can be most helpful in "nipping in the bud" evident illnesses, which so often go unrecognized by the non-medically trained individual. Many other chapters in this 1,000-page volume are of equal clarity. Such concise descriptions of the unusual, as well as the usual, ailments can be of inestimable value to their early recognition and prompt care.

The most common ailments, with their suggested care and some minor therapy, are included but, in the main, sound advice in this work is the hallmark.

A most welcome modern encyclopedia of simply-defined medical terms, with brief commentary, is contained in over half of the volume. This innovation, plus current authoritative revision, makes it two books in one, and an excellent home-reference adviser to be highly recommended for any home.

M. R. Cronen, M.D.

CARE OF THE PATIENT WITH A STROKE: by Genevieve Waples Smith, R.N., M.A.; published by Springer Publishing Company, Inc., New York, N. Y.; 142 pages; price, $2.75.

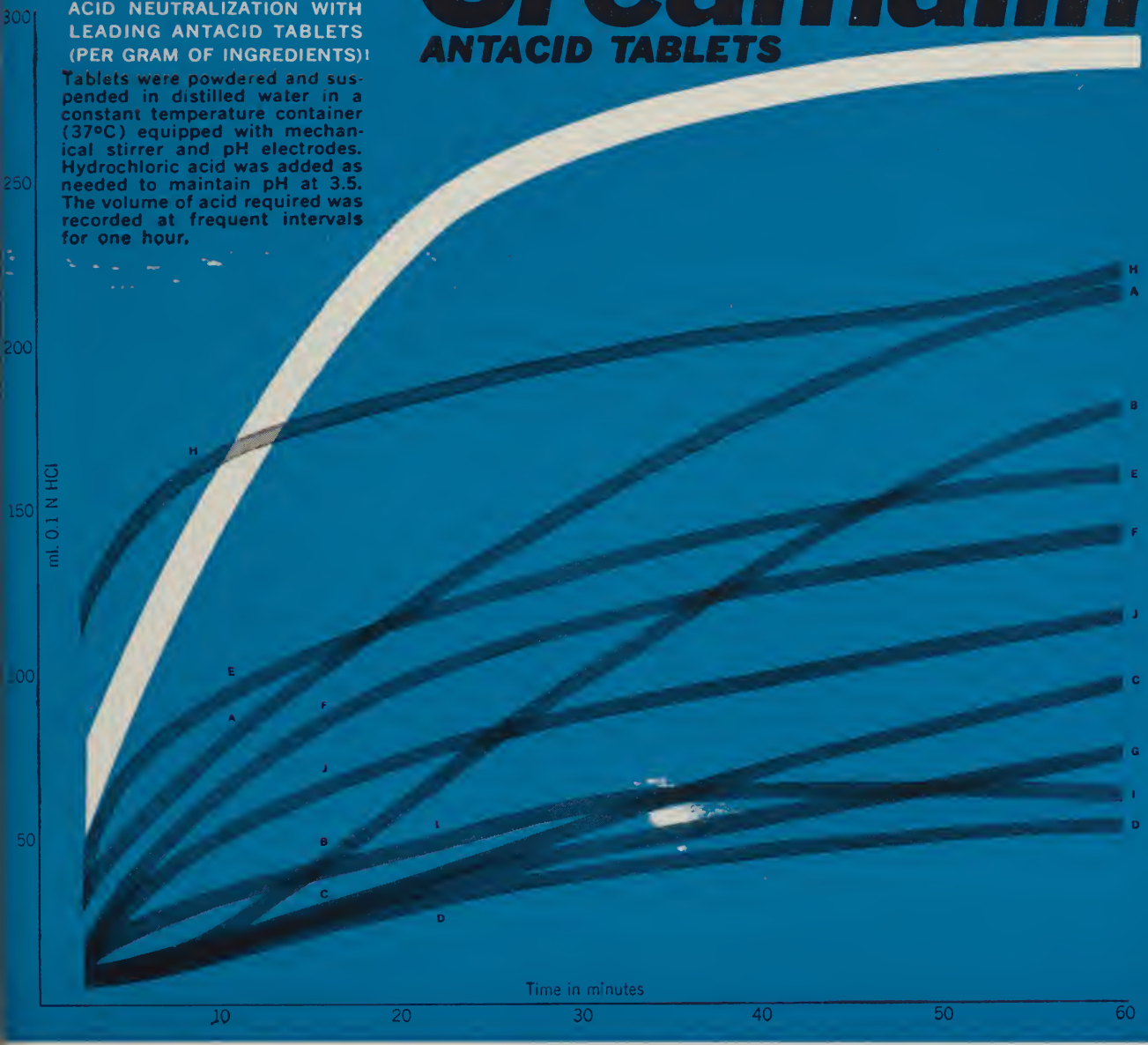
This 142-page cloth bound book, designed as a handbook for the patient's family and the nurse in the care of the patient with the stroke, is considered a very important contribution. It emphasizes the total care necessary in the recovery of function and return to society of the patient having suffered a cerebral vascular accident with attendant hemiplegia.

This book is written very plainly and simply and has a very personal appeal because the author speaks from her own experience as a registered nurse whose husband suffered a "stroke." She outlines the personal needs of the patient from the time he leaves the hospital until maximum recovery has occurred. She goes into details as to the daily home care of the patient, stressing the need to make him as independent as possible within his physical abilities.

(Continued on Page 376)

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1. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:380, July, 1959. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:384, July, 1959.

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IN THE BOOKS

(Continued from Page 374)

The psychological implications of regaining independence is considered in the patient's total recovery. The book points out realistic problems such as preparing the patient and family to accept limitations and how to adjust to residual disability. The value of persistence in physical restoration and training programs is well illustrated.

Many phases of the patient's training to become independent are gone into in detail, such as regulating visiting, speech therapy, the psychological management of the patient, detailed exercises and other physical treatment, and training in activities of daily living.

There are some discrepancies in the descriptions of techniques in application of physical measures, but these are insignificant when the total value of the book is considered.

This book is highly recommended to nurses and to the family who has experienced the disabling consequences of a cerebral vascular accident in one of its members. In addition, this book is recommended to physicians who desire a practical guide for their patients recovering from a cerebral vascular accident.

Rex O. McMorris, M.D.

Books Received

Following is a list of books received by the Association for review. Those considered of particular interest to Journal readers will be reviewed as space permits. All complimentary copies of books received are turned over to the University of Louisville-Jefferson County Medical Society Library. Inquiries concerning a particular book should be made to the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky.

MEDIEVAL and RENAISSANCE MEDICINE: by Benjamin L. Gordon, M.D., F.I.C.S.; published by Philosophical Library, Inc., New York.

THE STORY OF DISSECTION: by Jack Kevorkian, M.D.; published by Philosophical Library, Inc., New York.

DOCTOR STRAND: by Boris Sokoloff, M.D., Ph.D., published by Vantage Press, Inc., New York.

RELIGION AND NURSING: by Samuel Southard; published by Broadman Press, Nashville, Tenn.

THE CLONAL SELECTION THEORY OF ACQUIRED IMMUNITY: by Sir Macfarlane Burnet; published by Vanderbilt University Press, Nashville, Tenn.

BABIES BY CHOICE OR BY CHANCE: by Alan F. Guttmacher, M.D.; published by Doubleday & Company, Inc., Garden City, N. Y...

CHRISTOPHER'S MINOR SURGERY: by Alton Ochsner, M.D., F.A.C.S., and Michael E. DeBakey, M.D., F.A.C.S.; published by W. B. Saunders Company, Philadelphia and London.

A DOCTOR'S LIFE OF JOHN KEATS: by Walter A. Wells, M.D.; published by Vantage Press, New York, Washington and Hollywood.

180 Attend KAGP Seminar

A total of 158 physicians from Kentucky, Indiana and Ohio registered for the Northern Kentucky Seminar of the Kentucky Academy of General Practice held on January 21 at the Sheraton Gibson Hotel in Cincinnati. With guests and 11 speakers, the attendance totaled 180. William K. Willard, M.D., dean of the College of Medicine, University of Kentucky, delivered the luncheon address.



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Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.[3]

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1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. *6*:1821 (Dec., 1955).

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. *9*:897 (June, 1958).

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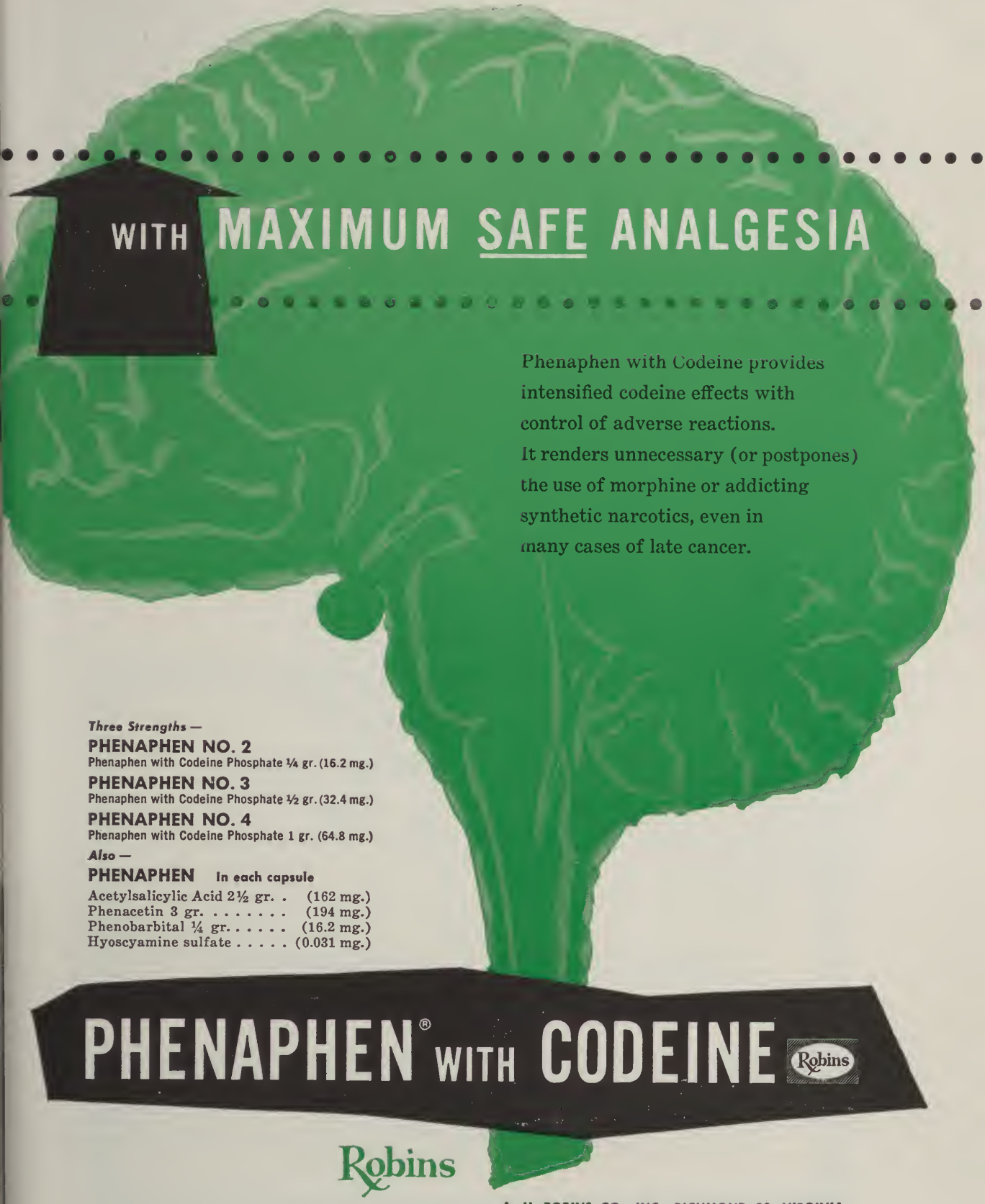
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PERTINENT PARAGRAPHS

"Clinical Pathology" is announced as the subject of a postgraduate course to be offered in Cleveland, March 31 and April 1, by the Frank E. Bunts Educational Institute affiliated with the Cleveland Clinic Foundation. Sponsored by the Cleveland Society of Pathologists, the course will be held in the North Clinic Building, according to Charles L. Leedham, M.D., director of education for the Bunts Institute. Registration will be $25.

A grant of $146,275 by The John A. Hartford Foundation, Inc., of New York to the American College of Surgeons to inaugurate a program for improving the medical management of the surgical and injured patient was announced on February 1. "This grant will permit the College to enlarge its long-established activities in the field of trauma, both at the national and local levels," said I. S. Ravdin, M.D., chairman of the College's Board of Regents.

"Nutrition In Tooth Formation and Dental Caries" is announced as the subject of the eighth symposium sponsored by the American Medical Association's Council on Foods and Nutrition, to be held May 19 at the Statler Hotel in Boston. The meeting is scheduled as an integral part of the annual meeting of the Massachusetts Medical Society, one of the co-sponsors which also include the Harvard School of Dental Medicine and the Massachusetts Dental Society.

The Fourth Postgraduate Course on Fractures and Other Trauma, sponsored by the Chicago Committee on Trauma of the American College of Surgeons, is scheduled for April 27-30 at the John B. Murphy Memorial Auditorium in that city. Teachers from the five Chicago medical schools, chiefs of services from the leading Chicago hospitals and a number of distinguished guest speakers will appear on the program. The registration fee is $50. Inquiries should be addressed to the chairman of the committee on the course, John J. Fahey, M.D., 1791 West Howard Street, Chicago 26, Ill.

The Research Committee of the National Society for the Prevention of Blindness invites requests for research grants in 1960 and announces that grants will be made this spring on requests received by April 1. Funds are available for projects that may contribute to basic understanding of eye function and pathology or that may improve methods of diagnosis, treatment or prevention of blinding eye disease. Inquiries should be addressed to the Committee, 1790 Broadway, New York 19, N. Y.

The nation's 85 medical schools will share equally in National Fund for Medical Education grants totaling $637,500, it was announced last month in New York. The grants, amounting to $7,500 for each school, are the first to be made under the fund's medical-research program. The money is to be used for basic research.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #43: The patient was a 42-year-old married, colored, gravida 15, para 14, who was due by menses 5/12/58. Her last menstrual period was 9/5/57. She consulted her private physician in her fourth month of pregnancy, had a complete medical examination and seven prenatal visits. Her past history was negative.

She had pitting edema of the feet and ankles on her last three visits beginning 5/9/58. She was treated with "Diuril, rest and diet."

Labor apparently began spontaneously around 7 p.m. 5/27/58. The cervix was dilated 4 cm. and she was described as apparently making normal progress until 11:30 p.m. when she had profuse vaginal bleeding and the fetal heartbeat was described as weak. (No mention was made of cervical dilation at this time.) It was stated she had received analgesia.

Two consultants suggested transfusion and cesarean section. A classical cesarean section was done immediately under cyclopropane and oxygen. The patient was described as being in good condition and the baby was a normal 6 lb. 8½ oz. girl. At approximately 11:45 p.m. the patient's blood pressure fell to 0. She never regained consciousness. It was not stated whether the patient was still having excessive bleeding, merely that she expired at 3:45 a.m. in spite of transfusions of 2000 cc. blood, 1500 cc. plasma, 2000 10% G/W, Pitocin, Ergotrate, adrenalin, Levophed. The hemorrhage was described as entirely of uterine origin.

No autopsy was obtained.

Cause of death on the certificate was "uterine hemorrhage, postpartum, due to abruptio placentae totalis."

Comment:

The Committee felt the cause of death was indeterminable from the information at hand. They felt the death could possibly have been prevented. This case emphasizes the hazards of the grand multipara. The patient had adequate prenatal care and in spite of it died at delivery. Without knowledge of what an autopsy might have proved to the contrary, the clinical impression was that either a vascular accident or afibrinogenemia was the cause of death.

If afibrinogenemia were the correct interpretation, this would have been demonstrated by observing either absence of clotting in blood obtained from the patient during the terminal crisis, or prompt lysis of any unstable clots that might have formed. Fibrinogen is available through the Red Cross and can be flown if necessary to any area in the state. This writer knows of one life that was saved in a small hospital when the correct diagnosis was made in time to send for the fibrinogen via private plane and state police.

It should be mentioned that some fibrinogen is obtained through repeated blood transfusion, more especially if the blood is freshly drawn into plastic containers. The fibrinogen is quite expensive and should be administered only if indicated, since it is obtained from pooled plasma, and homologous serum jaundice can be a late complication.

	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apl.	May			
B P				120/80	110/70			100/70	120/70	100/70	140/70	118/70
Wt				138	143½			150	149½	153½	149¾	155½
Urine				neg.	neg.			neg.	neg.	neg.	neg.	neg.

RH +
Hgb 12.5 grams
VDRL neg.



IN LOW BACK PAIN...
more and more
reports show that
Trancopal
a true "tranquilaxant"
keeps the patient
on the job

THE FIRST TRUE "TRANQUILAXANT"

Trancopal®

relieves painful muscle spasm and relaxes the patient



Impressive numbers of patients with low back pain and other musculospastic conditions treated with Trancopal have been freed of symptoms and enabled to return to their usual activities, according to newly published clinical reports. In a recent study by Lichtman,[1] Trancopal brought excellent to satisfactory muscle relaxation to 817 of 879 patients. The patients in this group suffered from skeletal muscle spasm associated with low back pain (361 cases), stiff neck (128 cases), bursitis (177 cases), and other skeletal muscle disorders (213 cases). Side effects were rare (2 per cent of patients), and it was not necessary to discontinue medication in any of the patients. Lichtman comments: "Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[2]

When you prescribe Trancopal for musculoskeletal disorders, you can confidently expect that your patients will be relieved of the pain and stiffness. You can be sure of their speedy return to everyday work and recreation.

Mullin and Epifano call Trancopal "...a very effective skeletal muscle spasmolytic."[3] They found that Trancopal brought good to excellent relief to all of 39 patients with skeletal muscle spasm related to trauma, bursitis, rheumatoid arthritis, osteoarthritis, and intervertebral disc syndrome. (No side effects were noted except that one patient had slight dryness of the mouth.)

The pattern is similar in every new series reported: Ganz,[4] DeNyse,[5] Shanaphy[6] and Stough.[7]

Trancopal is a true "tranquilaxant"

Trancopal "...combines the properties of tranquilization and skeletal muscle relaxation with no concomitant change in normal consciousness."[6]

Relieves dysmenorrhea



Trancopal not only is valuable in treating patients with low back pain and other musculoskeletal disorders, but is also very effective in bringing relief from menstrual cramps and discomfort. Shanaphy suggests that Trancopal may help the patient by its combination of muscle relaxant and tranquilizing actions, and he finds that "...the continued use of chlormezanone [Trancopal] as a therapeutic agent in dysmenorrhea is advisable."[6] Trancopal was effective in 82 per cent of his series of 50 patients. In another study, which dealt with 52 adolescent girls and 23 women, Stough[7] reported that Trancopal gave complete or moderate relief in 86.4 per cent.

Alleviates tension

And, of course, Trancopal is also very useful in the treatment of patients in anxiety and tension states. As Ganz says, "...a most valuable drug for relieving tension, apprehension and various psychogenic states... allows the patient to use his energies in a more productive manner in overcoming his basic problems."[4]

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that relieves skeletal muscle spasm and relaxes psychogenic tension without troublesome side effects, and keeps the patient on the job.

Indicated for...

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Low back pain (lumbago)	Fibrositis	Anxiety and tension states
Neck pain (torticollis)	Ankle sprain, tennis elbow	Dysmenorrhea
Bursitis	Myositis	Premenstrual tension
Rheumatoid arthritis	Postoperative muscle spasm	Asthma
Osteoarthritis		Angina pectoris
Disc syndrome		Alcoholism

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Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.



Professional models used for photograph

References: 1. Lichtman, A. L.: Scientific Exhibit, meeting of the International College of Surgeons, Miami Beach, Fla., Jan. 4-7, 1959. 2. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 3. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 4. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 5. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 6. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 7. Stough, A. R.: *J. Oklahoma M. A.* 52:575, Sept., 1959.

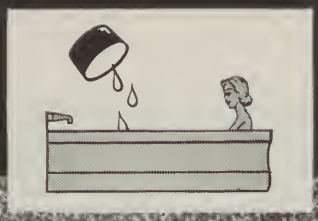
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1. Spoor, H. J.: N. Y. State J. Med. Oct. 15, 1958

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INCREASES AND MAINTAINS BLOOD FLOW FOR 10-12 HOURS

THAWS ICY HANDS AND FEET Roniacol Timespan promptly increases circulation in cold fingers and toes,[1] resulting in "less ischemic pain, improved pulses and increased skin temperature."[2] Action: specific dilation of peripheral vessels.[1] Result: Roniacol increases blood flow to ischemic extremities.[3-5] Improved blood flow further minimizes the chance of ulcerations associated with peripheral arterial insufficiency.

EACH DOSE ACTS FOR 10-12 HOURS New, sustained-release Roniacol Timespan provides convenience for your patients as well as daylong or nightlong relief of cold, aching extremities—one Timespan in the morning precludes forgotten midday doses, another at night permits comfortable, uninterrupted sleep.

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RONIACOL TIMESPAN for intermittent claudication, night cramps, cold hands and feet, in such peripheral vascular conditions as generalized or cerebral arteriosclerosis, Buerger's disease, varicose and decubitus ulcers, Meniere's syndrome[8] and vertigo due to impaired cerebral circulation.

DOSAGE: One or two Roniacol Timespan tablets in the morning and at night.
SUPPLY: Tablets of 150 mg, bottles of 50. When prolonged effects are not desired, prescribe Roniacol Tartrate Tablets, 50 mg, or Roniacol Elixir, 10 mg per teaspoonful (5 cc).

REFERENCES: 1. Reports on File, Roche Laboratories. 2. W. D. Westinghouse, Personal Communication. 3. E. C. Texter, et al., **Am. J. M. Sc.**, 224:408, 952. 4. M. M. Fisher and H. E. Tebrock, **New York J. Med.**, 53:65, 1953. 5. I. H. Richter, et al., **New York J. Med.**, 51:1303, 1951. 6. C. M. Castro and . De Soldati, **Angiology**, 4:165, 1953. 7. R. M. N. Crosby, **Am. J. M. Sc.**, 225:61, 1953. 8. J. Dosdos and G. E. Arnold, **Eye Ear Nose & Throat Month.**, 8:1035, 1959.

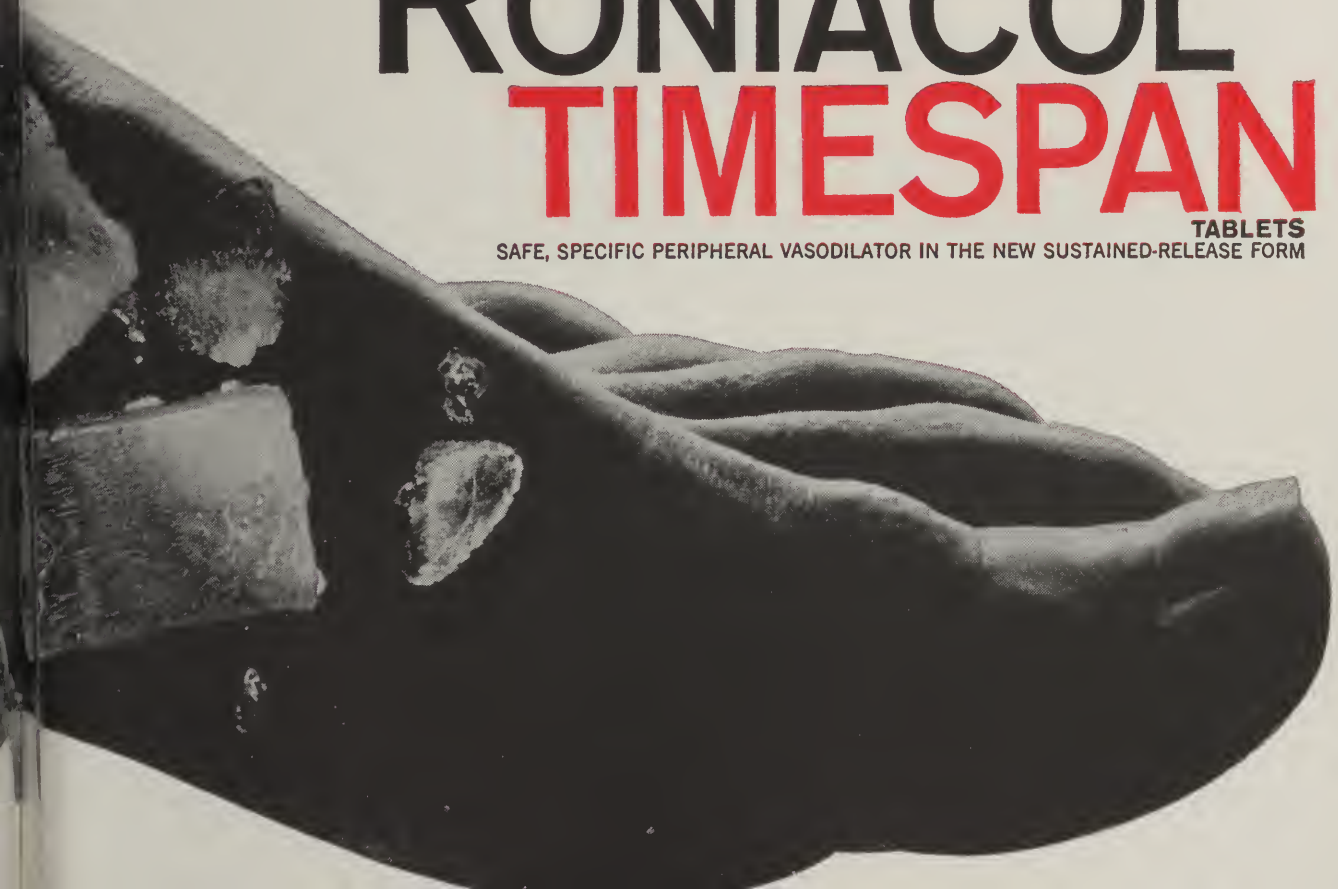
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RONIACOL TIMESPAN

TABLETS

SAFE, SPECIFIC PERIPHERAL VASODILATOR IN THE NEW SUSTAINED-RELEASE FORM



PUBLIC HEALTH PAGE

Radiological Health Regulations In Kentucky

RUSSELL E. TEAGUE, M.D.

Commissioner of Health
Commonwealth of Kentucky

IONIZING radiation is not a new area of public health interest in Kentucky, as is evidenced by the monitoring and consultation activities which have been going on at the State Department of Health for several years.

Unnecessary application, such as in shoe-fitting fluoroscope machines, has been discouraged. A reduction in the number of chest X-rays for tuberculosis screening has demonstrated the Department's intent to be as discriminate as possible in the use of radiation. Skin testing for tuberculosis is now generally employed for persons under 20 years old. The legitimate use of radiation as a purposeful tool has been enhanced through the Department's efforts to promote safe practices and by dispelling unjustified fears where no dangers exist.

In the past few years, we have witnessed the development of numerous new applications for nuclear and machine-produced radiation. The responsibility of protecting our public's health from unnecessary ionizing radiation, without hindering technological progress through undue restriction, is one which must be met squarely and now. The achievement of adequate protection depends largely on the intelligent cooperation of all radiation users. The Department of Health has an obligation to keep the public informed to a degree that due respect for radiation may be exercised with regard to poor practices and unnecessary exposures. It is hoped that the Department's program in these matters will be viewed by the public as an acceptable effort to do what is highly desirable.

An Ad hoc Radiological Advisory Committee composed of Kentucky radiologists was appointed in September, 1958, to provide counsel and guidance in developing regulations which would therefore not only meet public health needs, but which would be feasible as well from the viewpoint of those who must work with ionizing radiation. This group submitted copies of these regulations to members of their respective professional organizations so that the final committee recommendations were formulated after exhaustive consideration. Legislation relating to radiation from all other states was reviewed in order to add national perspective. The proposed regulations were then submitted to the United States Public Health Service for further comment.

The radiological health regulations were adopted by the State Board of Health and then presented to the Kentucky Advisory Council of Nuclear Energy. A hearing committee was set up to permit further consideration for persons who wished to present comments relative to these regulations. They were subsequently filed with the Legislative Research Commission.

While space is too limited for a lengthy review of specific regulations, a few pertinent comments seem desirable. The regulations do not attempt to place restrictions on the medical or dental professions as to the amount of radiation a person may receive for the useful purpose of diagnosis or therapy. This does not imply that good techniques and applications lack importance. New advances in equipment design now not only produce better X-ray images, but give added protection to both the doctor and his patients through built-in safeguards lacking in some older X-ray equipment.

Two basic approaches to health protection are taken in the regulations. The first of these has to do with competent operation by users of radiation devices or sources. Persons who are already qualified by law are not restricted by these regulations. Other persons must give evidence of their proficiency in their particular type, or types, of application. Acceptable evidence of competence will be developed by the Department with the advice of persons thoroughly versed in the various fields of usage. The second approach to health protection is to provide for dependable, good equipment, well maintained.

Supporting these primary considerations are regulations dealing with registration and approval of certain radiation sources and devices, the maintenance of minimum records and reports, the observance of some precautionary procedures, monitoring of nondiagnostic and nontherapeutic exposures of certain radiation levels, the proper disposal of radioactive wastes, and the construction and operation of nuclear installations.

Changes will be proposed in these regulations as new knowledge about man's response to radiation reveals their need and as technology makes them possible. The situation is dynamic and requires continuous appraisal by all, so that the maximum benefit may be derived from radiation usage with the least possible danger to individuals and the population at large.

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And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

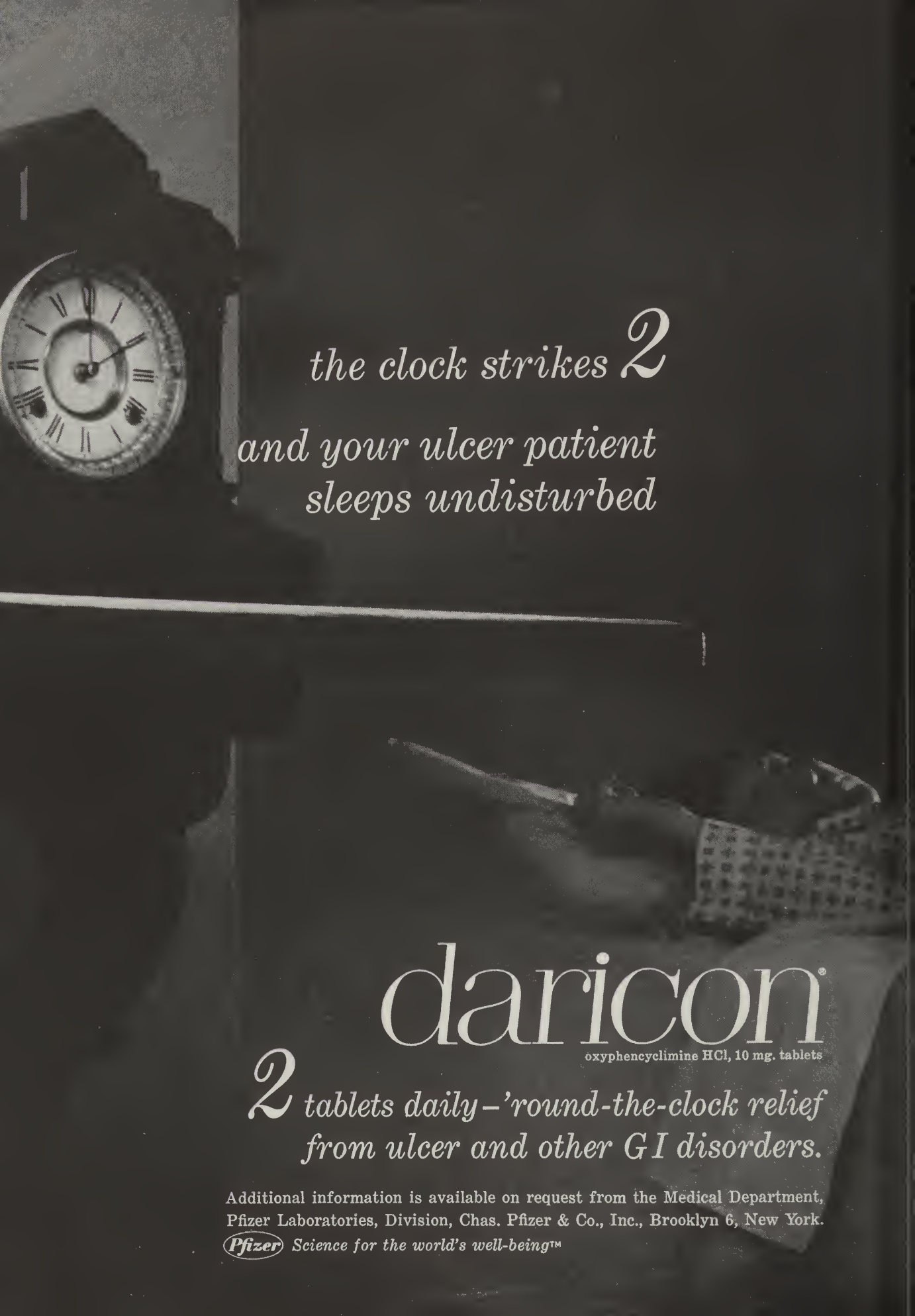
Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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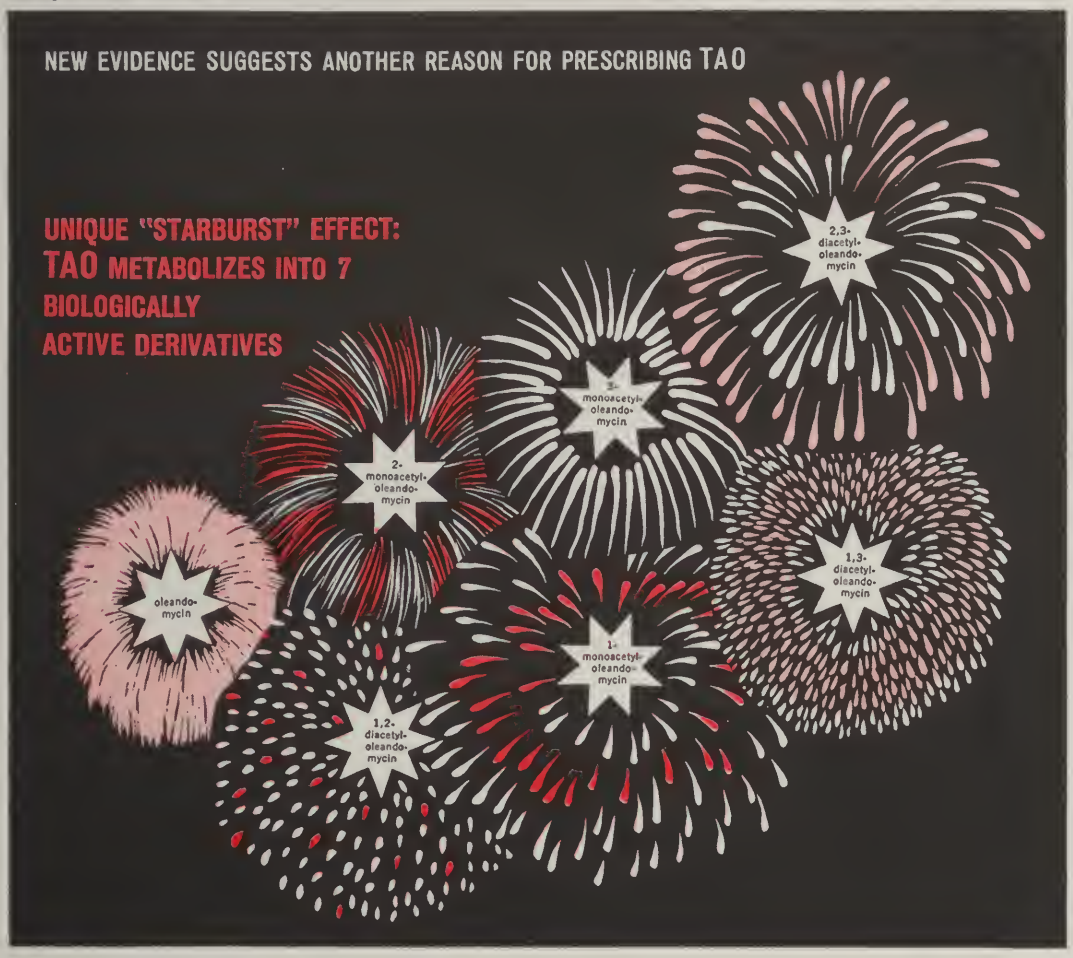
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1. English, A. R., and McBride, T. J.: Proc. Soc. Exper. Biol. & Med. 100:880 (Apr.) 1959. 2. Celmer, W. D.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 277. 3. English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8:420 (Aug.) 1958.

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Significance of complementary action of isomers in SYNCILLIN

The antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than that of either of its two component isomers alone against many important pathogens, including some penicillin-resistant staphylococci. This phenomenon has been described as *Isomeric Complementarity*.

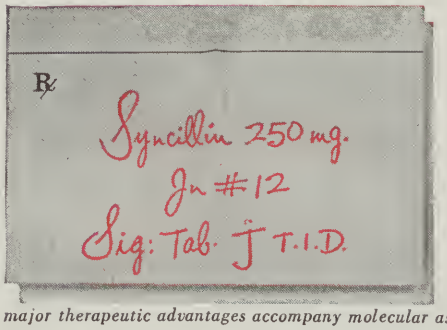
Significance of higher blood levels with SYNCILLIN

Higher blood levels may be of value with organisms of only moderate penicillin sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition, these higher levels may be necessary where there is infection in areas with a poor blood supply. Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue. Also, antibiotic activity of SYNCILLIN is directly proportional to oral dosage. Increasing the dosage may, therefore, enhance the drug's effectiveness in certain cases.

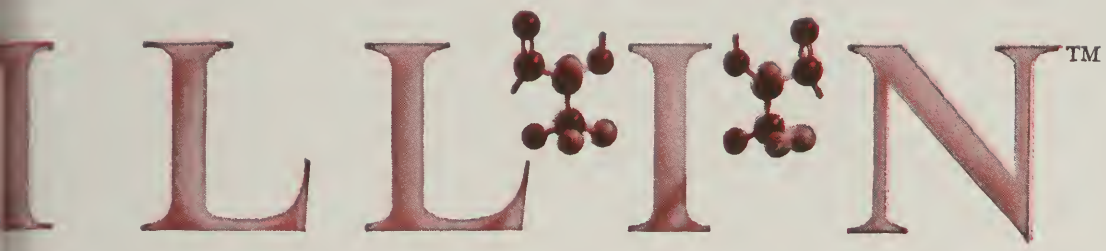
Efficacy of SYNCILLIN against staphylococci and other resistant organisms

Studies have shown that SYNCILLIN is effective *in vitro* against 60 to 75% of hospital "staph" strains, while penicillin G and penicillin V are now effective against only 30 to 50%.[1, 2] Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN would be expected to be the most effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal[3] and gonococcal[4, 5] infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



major therapeutic advantages accompany molecular asymmetry



Relation of intermittent high blood levels of SYNCILLIN to antibacterial efficacy

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations may be sufficient to permit complete eradication of sensitive pathogens. According to Eagle,[6] "Soon after penicillin attains effective concentrations, the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective. . . . The therapeutic significance of this postpenicillin recovery period is enhanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process *in vivo* continues for many hours after the drug itself has fallen to ineffective concentrations."

Reduced rate of inactivation of SYNCILLIN by staph penicillinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V or penicillin G. Penicillinase from *B. cereus* likewise inactivates SYNCILLIN less rapidly than penicillin V or G.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins. SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. *Therefore, the usual precautions for oral penicillin therapy should always be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.

If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Wright, W. W.: Microbiology Report to Bristol Laboratories Inc. 2. Morigi, E. M. E.; Wheatley, W. B., and Albright, H.: Paper presented at the Seventh Antibiotic Symposium, November 4-6, 1959, Washington, D.C. 3. Editorial: New England J. Med. **261**:305 (Aug. 6) 1959. 4. King, A.: Lancet **1**:651 (March 29) 1958. 5. Epstein, E.: J.A.M.A. **169**:1055 (March 7) 1959. 6. Eagle, H. and Musselman, A. D.: J. Bact. **58**:475, 1949.

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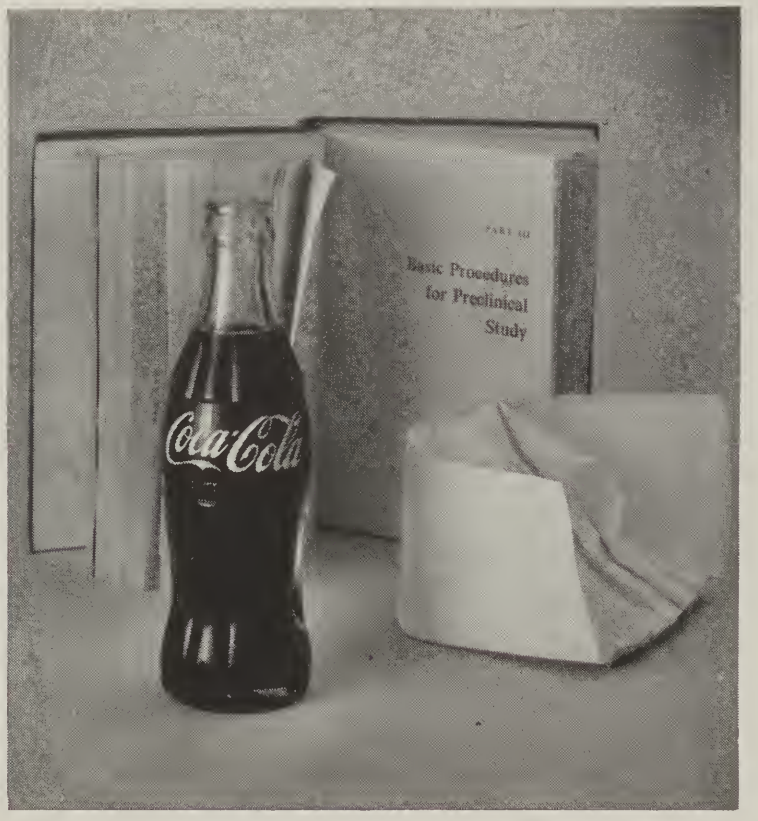
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PROPERTIES PERFORMANCE IMPORTANCE

PROPERTIES:

Greater inhibitory action ... lower daily intake than other tetracyclines

A unique new fermentation product of *Streptomyces aureofaciens,* DECLOMYCIN Demethylchlortetracycline achieves notably greater antibiotic activity against infections[2,4,7,8,10,14,19,20,24] because of two basic factors: (1) inherent potency, and (2) greater stability in most body fluids.[15,17,18,27] Actual clinical activity has, in many instances, been better than expected on the basis of *in vitro* sensitivity tests.[14,18,19]

Broad-spectrum control ... with far less antibiotic

Activity levels of DECLOMYCIN Demethylchlortetracycline are higher than those of previous broad-spectrum antibiotics. Hardier strains of various organisms appear to be somewhat more responsive.[4] Apparently some strains of Pseudomonas, Proteus and *A. aerogenes,* frequently refractory to therapy, are sensitive to DECLOMYCIN.[7,23,25,26]

DECLO

Sustained peak activity ...greater security of control

Prolonged retention and compatibility of DECLOMYCIN with body fluids provides peak activity between doses.[15,17,18,27] Inhibition of bacteria is more constant.

24-48 hours extra activity...protection against relapse

DECLOMYCIN maintains effective antimicrobial action for one to two days after stopping dosage.[7,14] Resurgence of a few viable pathogens, with relapse...and low patient defense against secondary bacterial invasion during the first post-therapy days . . . are largely offset.

MYCIN®



PERFORMANCE

Susceptibility Tests

Roberts, M. S., *et al.*[25]
New York, N. Y.

Pre-treatment sensitivity tests in 75 genitourinary patients showed DECLOMYCIN Demethylchlortetracycline to be superior against the large majority of organisms and in no instance inferior to tetracycline. DECLOMYCIN apparently has more effective coverage... several strains of *Proteus* and *A. aerogenes* responded.

Tolerance & Toxicity

Boger, W. P., and Gavin, J. J.[2]
Norristown, Pa.

Administration of the recommended 600 mg. (4 capsules) daily for 30 days to a small group of elderly patients revealed no hematologic, hepatic and urinary alteration or other abnormal finding. No clinical side effects were observed.

Gonococcal Infection

Marmell, M., and Prigot, A.[20]
New York, N. Y.

All except two of 63 patients with acute gonorrhea responded promptly to therapy with DECLOMYCIN. Fifteen received 250 mg. q.i.d. for one day, the remainder received 600 or 750 mg. in divided doses over one or two days. No side effects.

General Medicine

Lichter, E. A., and Sobel, S.[19]
Chicago, Ill.

One hundred and sixty-nine patients with various infections showed generally equivalent response to four dosage regimens, including the recommended level. Of 29 pneumococcal pneumonias, all recovered with 15 afebrile in 48 hours or less — except a few patients with preterminal underlying disease. All 42 scarlet fever patients recovered with 32 afebrile in 48 hours or less. Other patients also responded satisfactorily with few exceptions. No blood, liver or kidney toxicity found. G.I. side effects occurred in only 2 per cent at the recommended dosage, or less, and were easily reversible.

Respiratory Infection

Perry, D. M., *et al.*[22]
Seattle, Wash.

Good or fair response in 24 of 30 cases of acute bacterial pneumonia, and in all of six cases of acute bronchitis. Side effects occurred at higher dosage but were uniformly absent when dosage was limited to 600 mg. per day.

Various Infections

Finland, M., *et al.*[7]
Boston, Mass.

Eighty patients with various infections were treated with DECLOMYCIN Demethylchlortetracycline and an equal number with tetracycline. Therapeutic response was indistinguishable between the two groups. However, DECLOMYCIN Demethylchlortetracycline dosage was much lower (50 to 60 per cent of that of tetracycline.) In addition, incidence of side effects with demethylchlortetracycline was only half that experienced with tetracycline.

Pyelonephritis

Vineyard, J. P., *et al.*[29]
Dallas, Tex.

Therapy with DECLOMYCIN was successful in 12 of 13 patients with pyelonephritis. Sterile cultures were obtained in nine patients within six to 14 days. Among the organisms suppressed were strains of *A. aerogenes, E. coli* and paracolon bacillus. In most cases, DECLOMYCIN was used jointly with another antibiotic.

Soft Tissue Infection

Prigot, A., *et al.*[24]
New York, N. Y.

DECLOMYCIN was used alone or auxiliary to surgical measures in 150 cases of acute soft tissue infection, mostly ambulatory. Full resolution of infection was achieved in all cases, average length of treatment being six days. Dosage was 600 or 750 mg. daily. Side effects consisted of transitory G.I. disturbances in three cases.

DECLO

Urinary Infection

Trafton, H. M., and Lind, H. E.[28]
Brookline, Mass.

Clinical response was favorable in a majority of 50 cases of urinary tract infections with relief of symptoms, elimination, or marked reduction, of pyuria and with urine sterilization in some. DECLOMYCIN Demethylchlortetracycline was administered in one-half to one-third the daily milligram level of related antibiotics, for 8 days.

No significant diarrhea occurred in any case although mild nausea and upper G.I. symptoms were fairly common. Phototoxicity occurred in six cases.

Antibiotic-Resistant Infections

Compilation of reports of 210 clinical investigators.[23]

In 570 treated for a great variety of infections, DECLOMYCIN was successful in resolving infection or in effecting marked improvement in 81 per cent, after failure of other antibiotics.

Pediatric Infection

Fujii, R., *et al.*[9]
Tokyo, Japan

Therapeutic results, elicited in 309 pediatric patients with average daily dosage of 15 mg./kg., were equal to those produced by 30 mg./kg. of buffered tetracycline preparations. Satisfactory results were obtained in 75 per cent. No appreciable side effects when 15 mg./kg./day dosage was not exceeded.

Pediatric Infection

Hall, T. N.[12]
San Francisco, Cal.

All eight cases of ophthalmic, respiratory or otic infection responded to four to twelve days of DECLOMYCIN therapy (5 recovered, 2 greatly improved, 1 improved). One skin reaction, in a case receiving the higher trial dosage of 7 mg./lb. daily, occurred.

Pneumonias

Duke, C. J., *et al.*[5]
Washington, D. C.

Results were satisfactory in all 32 cases of acute bacterial penumonia, excepting for two caused by non-susceptible organisms. Over half had been complicated by pleural, suppurative, bronchial, or underlying structural lung problems. Dosage was low. No toxicity found. Acceptance and toleration were excellent.

Intestinal & Respiratory Infection

Hartman, S. A.[13]
Sherman Oaks, Cal.

Six cases of g.i. infection (diverticulitis, ileitis, colitis) responded in three to eight days on the lower milligram intake...even after failure in most with sulfa, neomycin or penicillin-streptomycin. Complete recovery was gained in 5 respiratory cases on a shorter schedule; another withdrew with occurrence of thrush. No other side effects were reported.

Respiratory Infection

Feingold, B. F.[6]
San Francisco, Cal.

All 13 upper or lower respiratory infections demonstrated very good response in 2-3 days on recommended dosage. No side effects were reported.

Various Infections

Compilation of reports of 210 clinical investigators.[23]

Of 1,904 patients with adequate follow-up treated for a wide diversity of infections, 87 per cent were reported as cured or improved. Most patients received one 150 mg. tablet every 6 hours. Therapy usually was for three to eight days. Side effects, mostly referable to the gastrointestinal tract, occurred in 200 patients.

PERFORMANCE

MYCIN®



PERFORMANCE *(continued)*

Respiratory Infection & Others

Gates, G. E.[11]
South Bend, Ind.

Of 65 cases, predominantly respiratory infections, but including some of cystitis and cellulitis, 50 had a good response, 12 were fair and three were failures. One of the failures was a case of chronic ulcerative colitis and two were respiratory infections. The only complication was a slight vulvular pruritus and burning tongue occurring near the end of a week's treatment of residual pneumonitis.

Pustular Dermatoses

Kanof, N. B., and Blau, S.[16]
New York, N. Y.

Eighty-five per cent of 67 patients responded with excellent or good results on a DECLOMYCIN schedule of one 150 mg. capsule q.i.d. for two to twelve weeks. Three poor responses were related to highly resistant organisms. No pruritus or drug eruptions developed. Only four cases showed nausea or diarrhea in the long therapeutic course.

Surgical Infection

Floyd, R. D., and Anlyan, W. G.[8]
Durham, N. C.

Successful results were generally obtained in 60 patients given 600 mg. DECLOMYCIN daily (or slightly less) for five to 15 days. No infection developed in the clean or contaminated prophylaxis group. Most frank infections responded...including several refractory to previous antibiotics. No toxicity evidenced. Intestinal toleration was excellent.

Wound Infections & Others

Meyer, B. S.[21]
Birmingham, Ala.

Thirty-five cases, chiefly prophylactic, and some traumatic-surgical wound infections were treated usually on one capsule DECLOMYCIN q. 6 h. for two to eight days. Over 80 per cent responded, including one with Pseudomonas etiology. Minor itching or nausea occurred in two; prominent nausea developed in one on a q. 4 h. schedule.

Topical & Wound Infections

Stewart, J.[26]
New Orleans, La.

Of 21 patients followed, 15 completely recovered, four improved in four to 42 days on 600 mg. daily. Seven had not responded to various other therapies. One had *A. aerogenes* predominance, complicated by Proteus and *E. coli*. Cases were traumatic-surgical-topical infections with some respiratory. One questionable reaction of anemia was encountered.

Oral Infection

Arbour, E. F.[1]
New Orleans, La.

Of four patients treated, three responded to one capsule DECLOMYCIN q. 6 h. for three days. No change in one case of chronic proliferating periodontitis. No adverse reactions seen.

Brucellosis

Chávez, Max, G.[3]
Mexico, D. F.

All nine patients infected with *Brucella melitensis* were afebrile on fourth or fifth day of DECLOMYCIN therapy and asymptomatic within 15 days. Treatment lasted for 45 days. No relapses occurred. Hepatic, renal, or hematologic toxicity was not seen. Minor or occasional intestinal reactions in some cases did not require discontinuance.

DECLO

IMPORTANCE...

in the average patient – DECLOMYCIN reduces the possibility of gastrointestinal intolerance and increases the likelihood of an uneventful therapeutic course. Variants of an infecting organism are less likely to survive the high, sustained activity and post-dosage control. Minor or major reverses or "setbacks" during therapy may be avoided. Susceptibility to secondary infection when dosage is terminated is counteracted by the "extra-day" activity.

in mixed infections–DECLOMYCIN provides satisfactory control of conditions involving multiple pathogens. Since organisms vary in sensitivity at given antibiotic levels, the higher DECLOMYCIN activity tends to inhibit a greater proportion of the less susceptible strains. Remission and bacteriologic cure can thus progress at a faster pace.

in the absorption-deficient – The high activity/intake ratio of DECLOMYCIN provides a wider margin of security for those with disturbed or abnormal absorption or with underlying gastrointestinal dysfunction. Inhibitory levels remain more than adequate in most.

under adverse host conditions–In debility, malnutrition, neoplasm, diabetes, or other organic, chronic or underlying disease, DECLOMYCIN may be vital to successful resolution of infection. *Generally in geriatrics,* for the same reason, DECLOMYCIN should often be a broad-spectrum of choice.

if an occasional dose is missed – The sustained action of DECLOMYCIN protects against possible loss of control. In the sleeping patient, an occasional dose may be foregone without adverse effect, while benefits of such rest are gained. Arbitrary rejection of a dose by pediatric or geriatric patients... simple forgetfulness... or postponing a dose will not appreciably reduce antibiotic activity provided these do not occur frequently.

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IMPORTANCE

DECLOMYCIN®

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a masterpiece of antibiotic design

CAPSULES, 150 mg., bottles of 16 and 100. *Dosage:* Average adult 1 capsule four times daily.

PEDIATRIC DROPS, 60 mg./cc. (custard flavor) in 10 cc. bottle with calibrated dropper. *Dosage:* 1-2 drops (3-6 mg.) per pound body weight per day—divided into 4 doses.

ORAL SUSPENSION, 75 mg./5 cc. teaspoonful (custard flavor) in 2 oz. bottle. *Dosage:* 3-6 mg./lb./day—divided in 4 doses.

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Because of the infrequency of the disease in this age group, its sudden onset, the profusion of inconsistent presenting symptoms, and because the accompanying symptoms of anorexia and vomiting are also characteristic symptoms of many other ills of infancy.

Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes *8*:289, 1959.

for those pediatric puzzlers..."A routine urinalysis and blood sugar should be done whenever the possibility of diagnosing diabetes is entertained."*

DIABETES MELLITUS AT AGES 1 TO 5

Order of Frequency of Presenting Symptoms in 110 Patients

Symptoms	No. of Patients	Per cent of total group
Polyuria	93	84.5
Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
Headache	1	0.9
Abdominal cramps	1	0.9

Adapted from Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.*

the standardized urine-sugar test for reliable quantitative estimations

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- full-color calibration, clear-cut color changes
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IN ANXIETY—RELAXATION RATHER THAN DROWSINESS

STELAZINE®

brand of trifluoperazine

'Stelazine' has little if any soporific effect. ". . . patients who reported drowsiness as a side effect mentioned that they did not fall asleep when they lay down for a daytime nap. It is quite possible that, in some instances, 'drowsiness' was confused with unfamiliar feelings of relaxation."[1]

'Stelazine' is unique among tranquilizers because it relieves anxiety whether expressed as agitation and tension or as apathy, listlessness and emotional fatigue.

Available for use in everyday practice: Tablets, 1 mg., in bottles of 50 and 500; and 2 mg., in bottles of 50.

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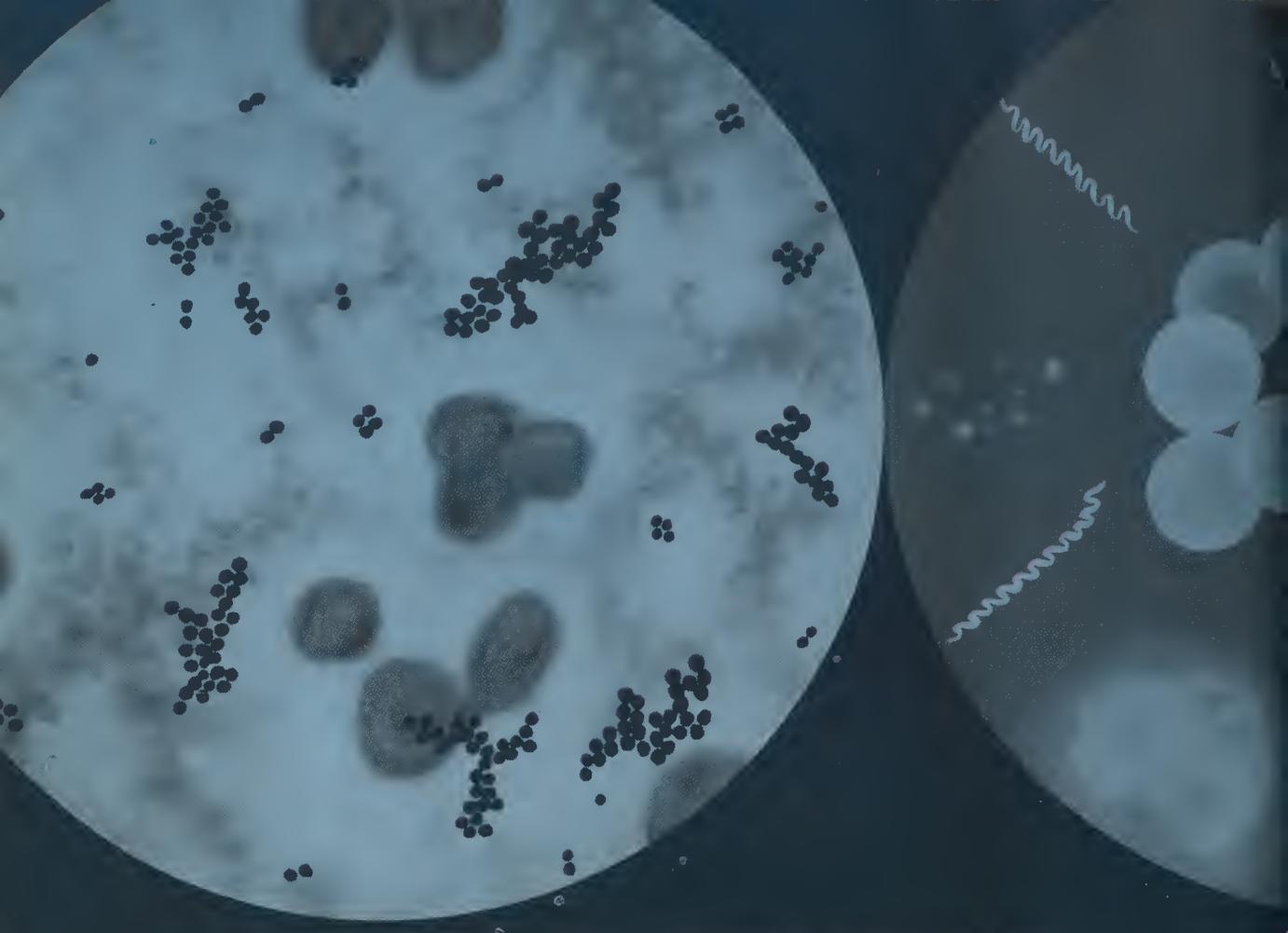
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KENTUCKY STATE MEDICAL ASSOCIATION
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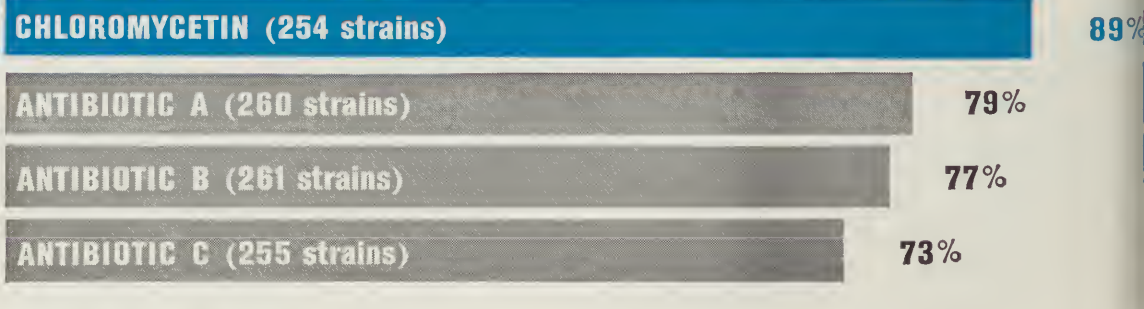
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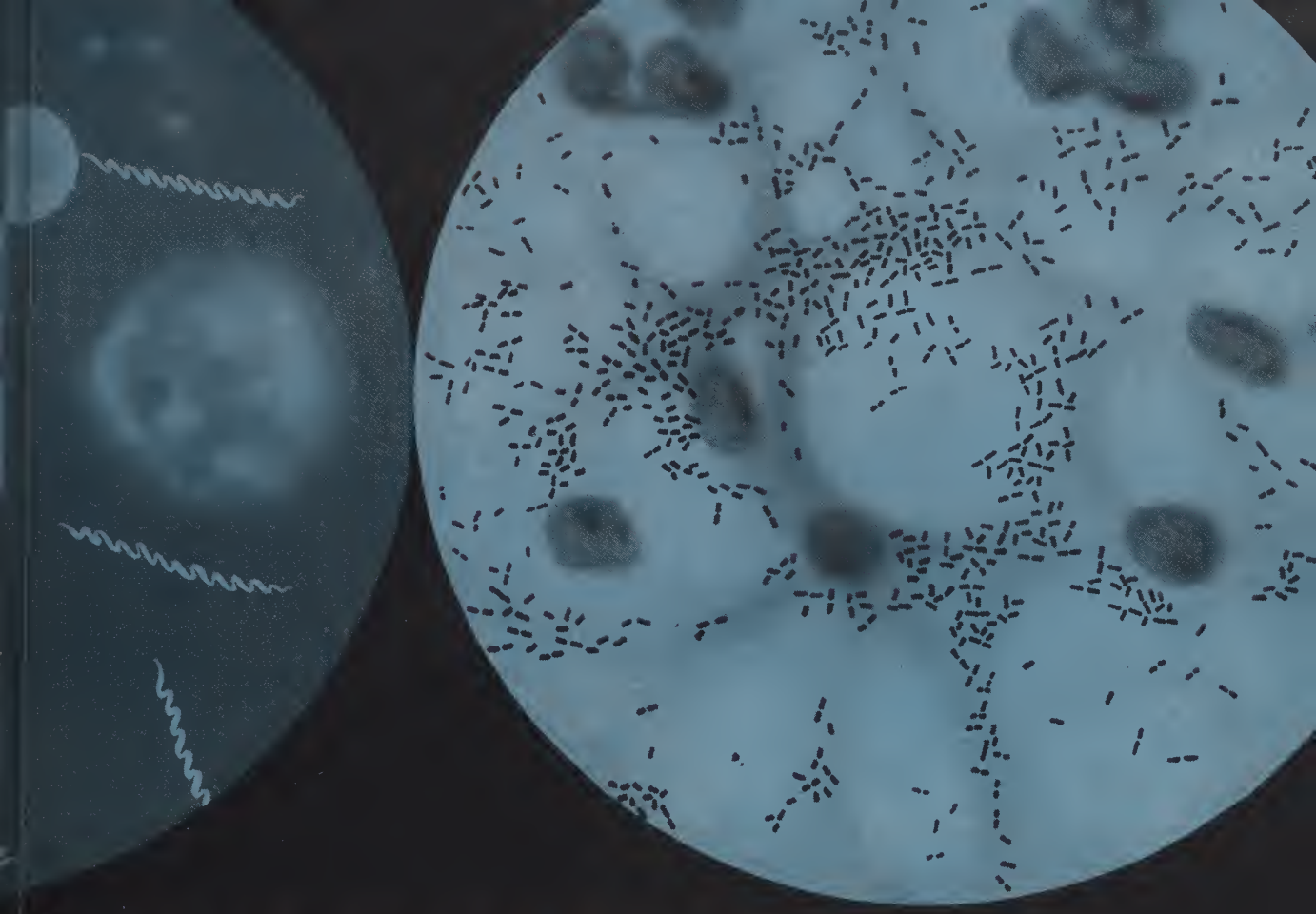
In the struggle against sepsis, CHLOROMYCETIN — effective "...against most bacteria, Rickettsia, Treponema, and some viruses..."[1] — has proved a dependable weapon in a variety of infections.

"Over 90 per cent of staphylococci isolated from infections in most institutions are relatively sensitive to chloramphenicol."[2] In a study of a significant number of gram-negative organisms it was found that CHLOROMYCETIN was more effective in *in vitro* sensitivity tests than were other widely used broad-spectrum antibiotics.[3] Moreover, through the years, the incidence of strains of bacteria resistant to CHLOROMYCETIN has remained virtually constant and strikingly low.[4-7]

IN VITRO SENSITIVITY OF GRAM-POSITIVE ORGANISMS TO CHLOROMYCETIN AND TO THREE OTHER BROAD-SPECTRUM ANTIBIOTICS*



*Adapted from Leming & Flanigan.[3]



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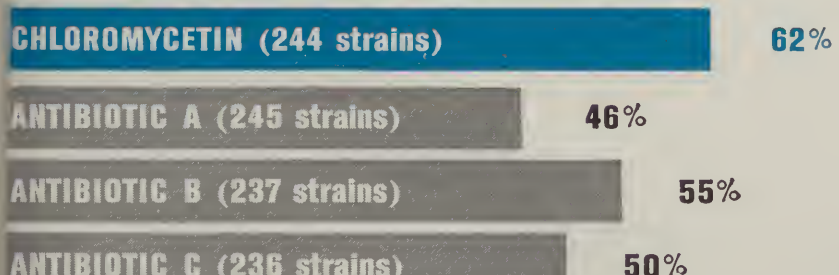
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ferences: (1) Morton, J. J.: *Yale J. Biol. & Med.* **31**:397, 1959. (2) Rogers, D. E., & Louria, D. B.: *New England J. Med.* **261**:86, 1959. Leming, B. H., Jr., & Flanigan, C., Jr., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1958-1959, New York, Medical Encyclo- dia, Inc., 1959, p. 414. (4) Edwards, T. S.: *Am. J. Ophth.* **48**:19, 1959. (5) Olarte, J., & de la Torre, J. A.: *Am. J. Trop. Med.* **18**:324, 1959. Suter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* **9**:38, 1959. (7) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* **30**:175, 1958.

N VITRO SENSITIVITY OF GRAM-NEGATIVE ORGANISMS TO CHLOROMYCETIN AND TO THREE OTHER BROAD-SPECTRUM ANTIBIOTICS*



*Adapted from Leming & Flanigan.[3]

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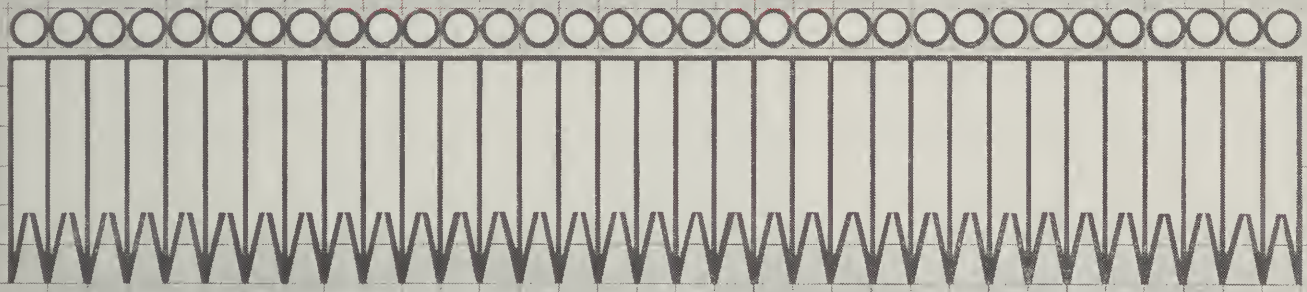
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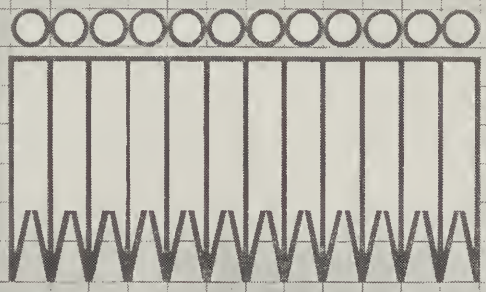
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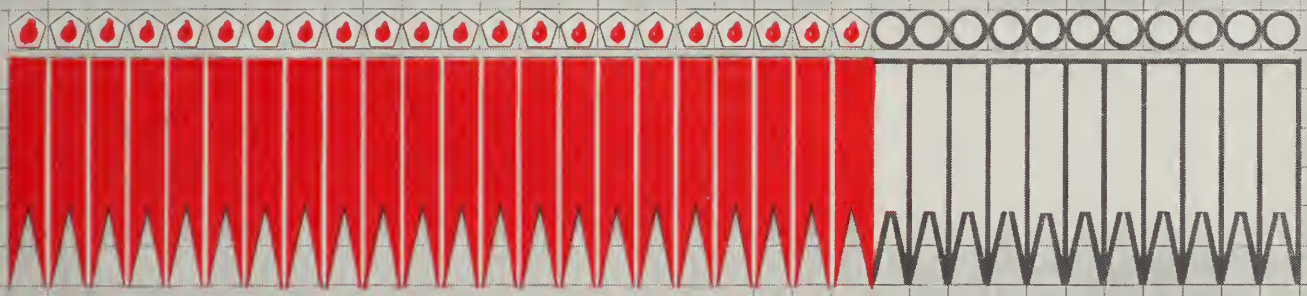
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who were refractory
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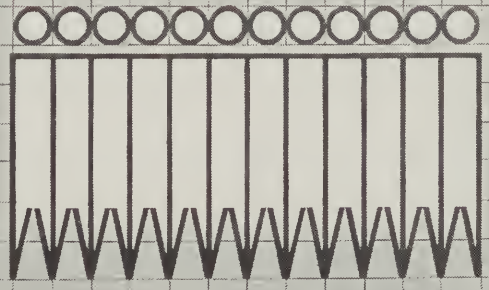
22 were successfully
treated with **Decadron**[1,2]

1. Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.
2. Bunim, J. J., et al.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

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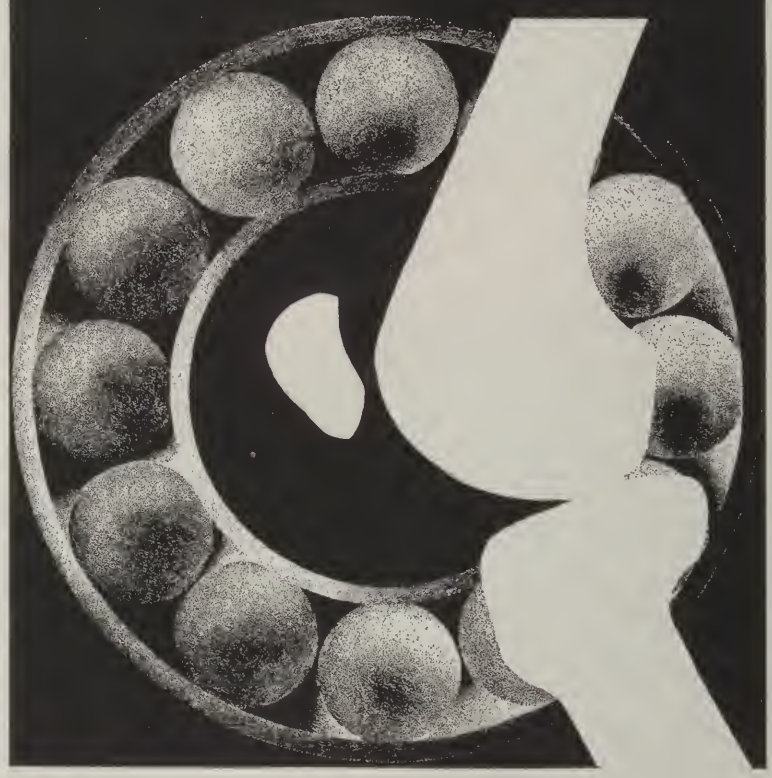
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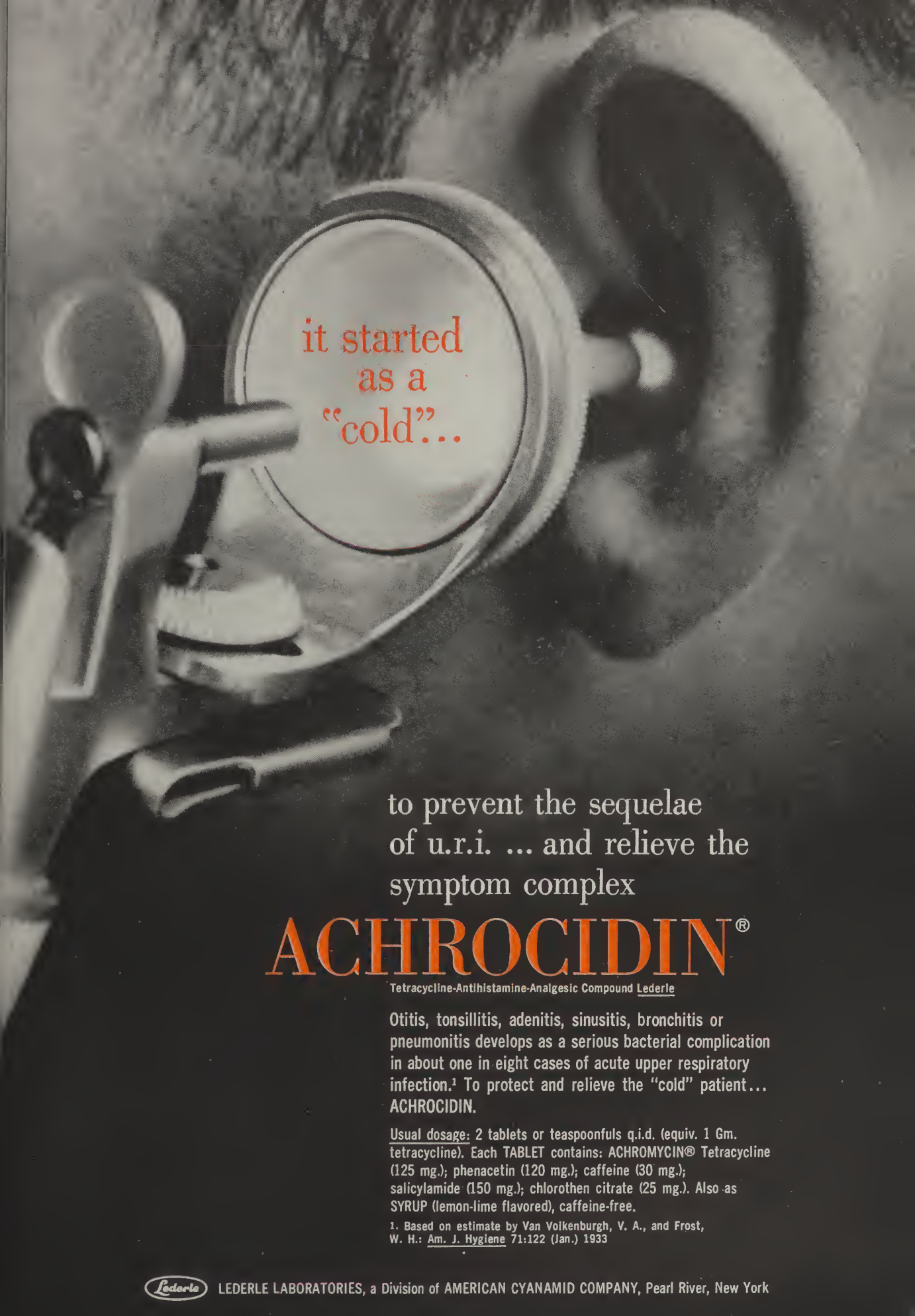
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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

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President's Page*



Dr. Cox
Vice-President—Central

Should Government Be In Competition With Private Enterprise?

The Government can do nothing as efficiently as can private enterprise. Many educational and charity organizations are asking government for so-called aid. Local and state governments ask for hand-outs from the Federal Government.

There are several groups of people. First, the people who are a part of industry—they may be employees or employers. They may be in a small or a large business, but they are all engaged in a creative type of work. They support themselves, their families, pay taxes (hidden and not hidden) to the local, state and Federal Government.

In a second group are the people engaged in non-creative type of work. They are employed by some branch of the government, and their salaries are paid by the people who are in creative employment, in the form of taxes.

A third group is retired, and a good portion of them are living on a dole through an agency of the Federal Government, Social Security. Every two years recently, Social Security has been broadened so that more money can be taken from the creative group and given to the less productive portion of our population. Just one of the methods of redistributing our wealth.

Several cities in Kentucky are clamoring to own their own utilities so they can buy power from the T.V.A., a federally-subsidized project. Any time any government agency goes into business in competition with private enterprise, the creative, productive work force is reduced. Every time lobbyists for federal "public power" push a government electricity project through Congress, you are taxed to pay the bill! The local area is being subsidized by the nation. We, in turn, are helping to support some area in some distant state. In other words, the T.V.A. serves seven states while it drains all fifty states.

Any project aided by federal money is a form of subsidy, which leads to more central government control. The only money that government can give is what it has already taxed from us. More government control means less individual freedom. The more people working for the government, the fewer people left for creative, tax-producing employment.

Some say that we are not keeping up with Russia in our defense preparedness. If and when we allocate more money to that effort, why, in all seriousness, should not that additional money come out of the billions the Government wastes every year before it starts laying waste the private economy?

The Government has a legitimate business, but it certainly is not being in competition with private enterprise.

David M. Cox, M.D.
Vice-President—Central

This is the first of a series of three guest articles written by the KSMA vice-presidents at the invitation of Irvin Abell, Jr., M.D., president.


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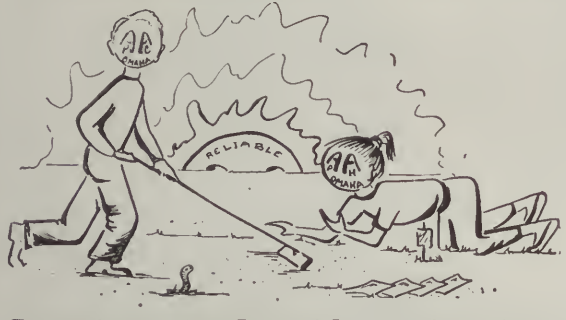
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1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.



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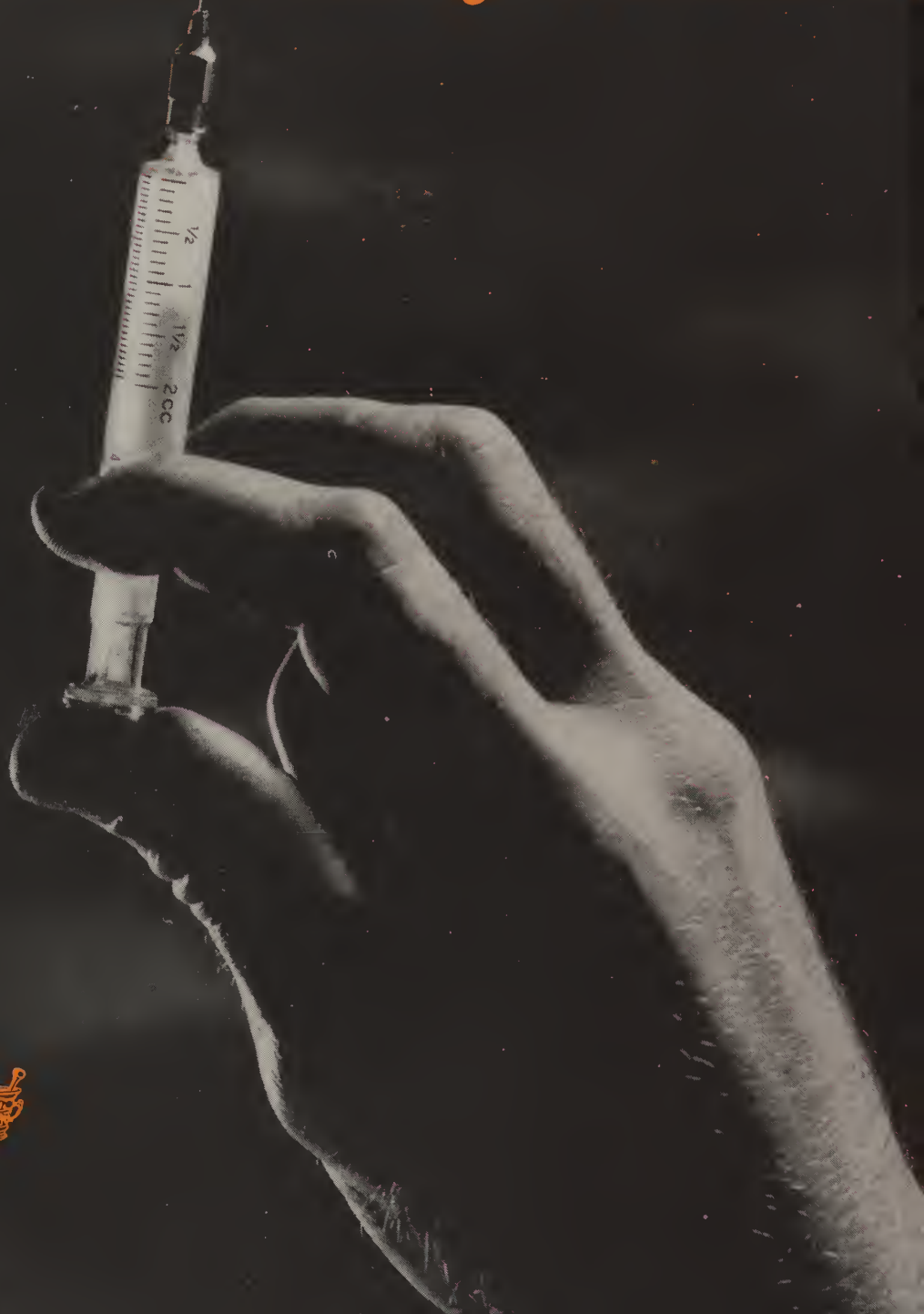
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"In many instances its effect has been dramatic and life saving . . ."[1]

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"There appears to be no doubt that kanamycin has been lifesaving in those instances in which organismal resistance precludes the use of other antimicrobials."[4]

Information on dosage, administration and precautions contained in package insert or available on request.

SUPPLY: KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in vial containing 2 ml. volume. KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in vial containing 3 ml. volume.

REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

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THE INSURANCE PAGE



Letter Authorized by KSMA's House Of Delegates Is Explained

A few weeks ago, every member of the Kentucky State Medical Association received a letter, signed by the president of the KSMA and by the chairman of the KSMA Council, relative to an action taken at the 1959 session of the House of Delegates of the Association.

Through this action, the House of Delegates requested that every physician who completes a Kentucky Physicians Mutual claim form should show on this form the charge he has made for the service rendered.

In response to this letter, a number of replies were received from members of the KSMA which indicated that some of them had misunderstood the meaning of the request. Several physicians stated that they had not been making any charge for filling out the forms.

This, of course, is evidence of a commendable attitude on the part of these men. It is to be hoped that no charge has ever been made by anyone for completing the Blue Shield forms. The completion of these forms is a service which benefits both patient and physician, since it assists the patient in recompensing his doctor for the services rendered.

The "charges" to which the recommendation of the House of Delegates has referred are the fees for services rendered by a physician to his patient and apply to the specific medical or surgical services mentioned on the Blue Shield form; such as the fee charged for performing an appendectomy, delivering a baby, or treating a pneumonia case in the hospital.

It should be emphasized that the purpose of asking physicians to give this information is not to make all physicians conform to a standard fee for each type of service rendered. On the other hand, a determination of the average fees charged by our physicians for each of the services mentioned in the Blue Shield contract should help the directors of the plan in determining how adequately the schedule of indemnities is helping subscribers to meet their medical expenses.

A study of these returns may show, for example, that the indemnity allowance of the Blue Shield contract covers 75 per cent of the average fees charged for a certain procedure, but only 25 per cent of the average fee charged for another procedure. Through such a study, it could be determined if there are inequities in the schedule of benefits; and steps could be taken to correct such inequities.

Another purpose of the action of the House of Delegates is to enable Blue Shield to comply with the terms of its certificate, and the ruling of the Kentucky Insurance Commissioner, not to pay in excess of the physician's charge for the service.

The cooperation of all physicians in this matter will not only help our Blue Shield plan to give more adequate protection to our people, but should help to eliminate a feeling on the part of some of our physicians that their services are not receiving a just share of the funds available through the premiums income received by the plan.

W. Vinson Pierce, M.D.



Diagnostic Quandaries

Colitis? Gall Bladder Disease?
Chronic Appendicitis?
Rheumatoid Arthritis? Regional Enteritis?

A DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.[1]

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica*. In 15 of these subjects, nine stool specimens were required to establish the diagnosis.[2]

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.[3]

Now treatment with Glarubin provides a means of differential diagnosis in suspected cases of amebiasis. Glarubin, a crystalline glycoside obtained from the fruit of *Simarouba glauca*, is a safe, effective amebicide. It contains no arsenic, bismuth, or iodine. Its virtual freedom from toxicity makes it practical to treat suspected cases without undertaking difficult, and frequently undependable, stool analyses. Marked improvement following administration of Glarubin indicates pathologically significant amebic infection.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis.

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1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. *6*:1821 (Dec., 1955).

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

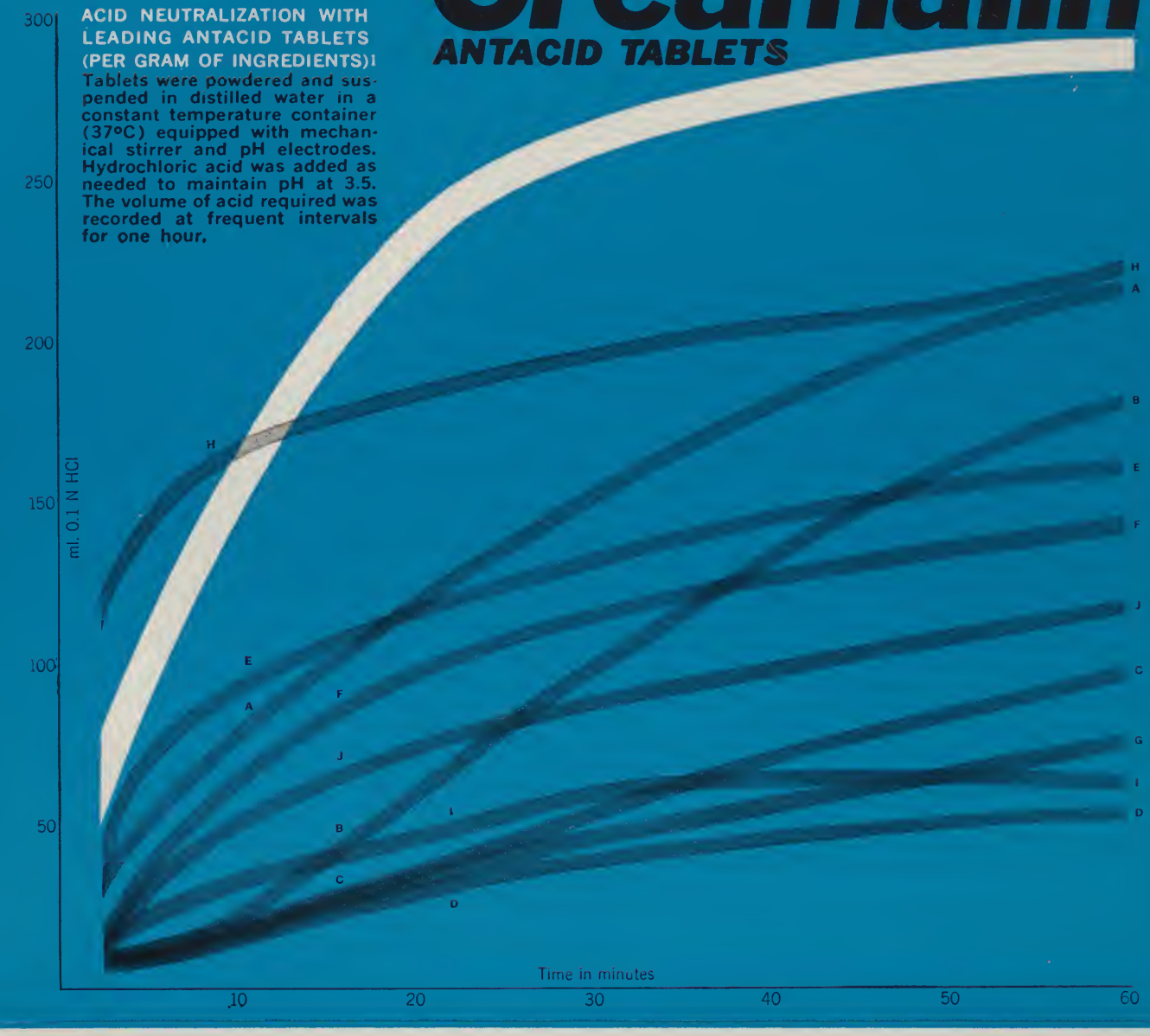
3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. *9*:897 (June, 1958).

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1. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:380, July, 1959. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:384, July, 1959.

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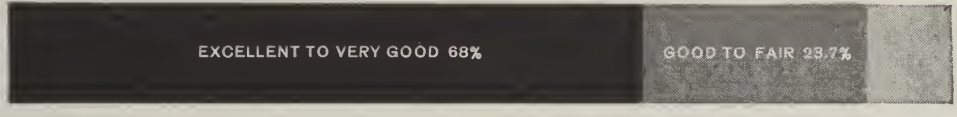
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*Investigators' reports to the Medical Department, Wallace Laboratories. (Total of 278 cases)

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SUPPLIED—as white, coated, 350 mg. tablets, bottles of 50; also available for pediatric use: 250 mg., orange capsules, bottles of 50

1. Kestler, O.: In The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. 2. Berger, F. M.; Kletzkin, M.; Ludwig, B. J.; Margolin, S., and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 3. Spears, C. E. and Phelps, W. M.: Arch. Pediat. *76*:287 (July) 1959. 4. Phelps, W. M.: Arch. Pediat. *76*:243 (June) 1959. 5. Friedman, A. P.; Frankel, K., and Fransway, R. L.: Papers presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 6. Kuge, T.: Unpublished reports. 7. Ostrowski, J. P.: Orthopedics *2*:7 (Jan.) 1960.

Literature and samples on request

Also available on request: The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. (185 pages)

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WASHINGTON NEWS DIGEST



Washington, D. C. — Congress has been warned against acting on legislation to provide health care for the aged before receiving the recommendations of next year's White House Conference on Aging.

Rep. Noah M. Mason (R., Ill.), ranking minority member of the House Ways and Means Committee which handles such legislation, put in the Congressional Record an exchange of correspondence with former Rep. Robert W. Kean (R., N.J.), chairman of the National Advisory Committee supervising preparations for the White House Conference next January.

Representative Mason said the correspondence "reveals the reason why Congress should await the results of the Conference."

"Let us not waste the $2 million we have already appropriated to bring thousands of good minds together to suggest solutions to problems of our aging population," he said. "Certainly we should get the benefit of their advice rather than enact legislation in haste and without proper study."

Dr. Blasingame Voices Warning

F. J. L. Blasingame, M.D., executive vice-president of the American Medical Association, also voiced this warning in a radio interview while he was in Washington for conferences with White House aides and Arthur S. Flemming, Secretary of Health, Education and Welfare.

Doctor Blasingame said that it would be "neither practical nor realistic" for Congress to act on such legislation until the White House Conference and other sources had compiled "more conclusive and complete information" on a nationwide basis.

Doctor Blasingame and other AMA representatives emphasized to President Eisenhower's aides and Flemming that the medical profession is unalterably opposed to any legislation, such as the Forand bill, that would use the Social Security system to provide health care for the aged.

In his letter to Mason, Kean predicted that "in all probability" most of the White House Conference's recommendations would be for "state and local activity" in dealing with the problems of the aged. Kean said that action at the state and local level "seems most effective."

NAM Attacks Forand Bill

The National Association of Manufacturers charged in a pamphlet that supporters of Forand-type legislation have exaggerated the health care needs of the nation's older people. The NAM pamphlet also said the Forand bill was an entering wedge for a cradle-to-grave compulsory health insurance plan.

Meantime, supporters of the Forand bill—particularly the AFL-CIO—continued an intensive pressure campaign aimed at Congressional approval of the legislation in this national election year when Congressmen are more susceptible to such pressure.

Another Democratic presidential hopeful, Sen. Hubert H. Humphrey (D., Minn.), reiterated his support for Forand-type legislation. He proposed a six-point program for aid for the elderly, including "an extension of the Social Security system to cover the cost of hospital and nursing home care for senior citizens."

Sen. John F. Kennedy (D., Mass.) a leading contender for the Democratic nomination for President, has introduced similar, but even broader, legislation.

Elsewhere on the national legislative front, prospects brightened for Congressional passage this year of a bill to permit physicians and other self-employed persons to set aside money for retirement.

The Administration, which last year opposed a bill with such provisions, appeared in mid-March to be ready to support it with modifications. The Administration shift improved the already favorable odds that both the Senate Finance Committee, where a House-approved bill was pending, and the Senate would approve such legislation this session.

Generic Vs. Trade Names

The issue of generic names vs. trade names in doctor's prescriptions came to the forefront in the Senate Monopoly Subcommittee's investigation of the drug industry.

Dr. Austin Smith, president of the Pharmaceutical Manufacturers Association, testified at a subcommittee hearing that "behind brand names lie the reputation, reliability and skill of the manufacturer." He said use of generic terms would restrict a physician's choice as to drugs and would transfer some of the physician's responsibility to the pharmacist.

"By brand name prescription, the doctor orders for a patient a specific product in which he has absolute knowledge of quality, purity and any side effects that might have importance for a particular patient," Doctor Smith said.

R. B. Robins, M.D., of Camden, Ark., who accompanied Smith at the hearing, submitted a similar statement. He said he used trade names because "It is simpler to write such a prescription and I can be assured that no substitution will be made by the drug-

(Continued on Page 497)



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Preferably, antibiotic therapy should be based on pretreatment culture of the offending pathogen, but in bacterial pneumonia the problem may well be too pressing to permit the required delay of 24 to 48 hours. A differential diagnosis among bacterial pneumonias, based on such clinical grounds as speed of onset, sepsis and pain may guide the choice of antibiotic for initiation of therapy.

Should clinical judgment dictate that antibiotic therapy be started immediately, at the same time a sputum sample or a subglottic swab can be sent to the laboratory for culture and sensitivity studies. If the response to the first antimicrobial agent proves unsatisfactory, a reasonable basis for changing therapy will then be at hand.

Choosing the Antibiotic

Since therapy must be started at once for bacterial pneumonia, it is advisable to choose a broad-spectrum antibiotic that quickly produces high levels of active agent (e.g., tetracycline phosphate complex, TETREX). Such an antibiotic probably has the best chance of controlling the pathogen, whether it be gram-negative or gram-positive. And if the laboratory report shows that the invading organism is much less sensitive to tetracycline than to other agents, the patient can then be changed to an appropriate antibiotic. If the difference in sensitivity is slight, then the possibility of side effects, sensitization, and toxicity should be evaluated before changing therapy to another antibiotic.

The greatest number of bacterial pneumonias are caused by pneumococci, which respond very well to penicillin, tetracycline, and chloramphenicol. Also, these antibiotics are usually effective against the other gram-positive coccal pneumonias. But penicillin is ineffective against the viral pneumonias and the gram-negative *Hemophilus influenzae* and *Klebsiella pneumoniae*. Although *K. pneumoniae* causes only about 1 to 2 per cent of pneumonia cases on the average,[1] these are apt to be acute and fulminating (Friedländer's pneumonia), with a high mortality rate if not effectively treated. Since pneumococcal pneumonia may be difficult to distinguish clinically from Friedländer's, except by gram-stained sputum smear, it may be wiser to start treatment with an agent also effective against Klebsiella.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reaction. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

Tetracycline is also clinically effective in primary atypical pneumonia.[3]

The tetracyclines (e.g., TETREX) have the advantage of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

No one would deny that appropriate antibiotic therapy has greatly reduced morbidity and saved many lives of patients with bacterial pneumonia. Nevertheless, general supportive measures in the care of patients remain important even today. Especially in the desperately ill patient, antibiotics are not considered as substitutes for the individual evaluation, clinical observation and judgment of the physician.

Some Micro-organisms Susceptible[a] *to Tetracycline* (TETREX)[b]

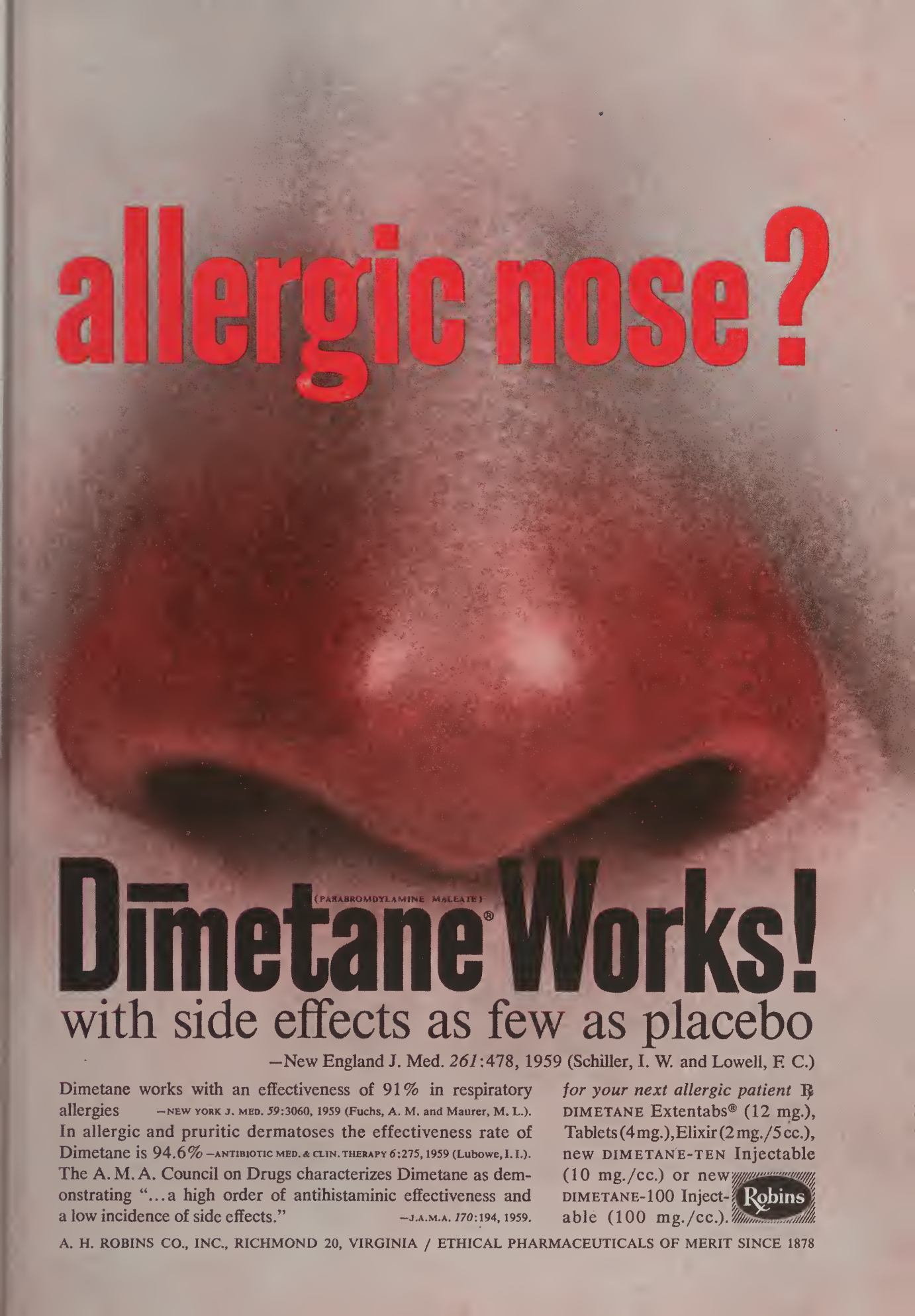
Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; *C. diphtheriae; B. anthracis; E. coli;* Proteus; *A. aerogenes; Ps. aeruginosa; K. pneumoniae;* Shigella; Brucella; *P. tularensis; H. influenzae; T. pallidum;* Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; *E. histolytica; D. granulomatosis.*

a Some strains are not susceptible.

b Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics. 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

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—New England J. Med. 261:478, 1959 (Schiller, I. W. and Lowell, F. C.)
Dimetane works with an effectiveness of 91% in respiratory allergies —NEW YORK J. MED. 59:3060, 1959 (Fuchs, A. M. and Maurer, M. L.).
In allergic and pruritic dermatoses the effectiveness rate of Dimetane is 94.6% —ANTIBIOTIC MED. & CLIN. THERAPY 6:275, 1959 (Lubowe, I. I.).
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1. Karnaky, K.J.: Med. Record and Annals, Houston 46:296 (Nov. 1952).

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1. A.M.A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

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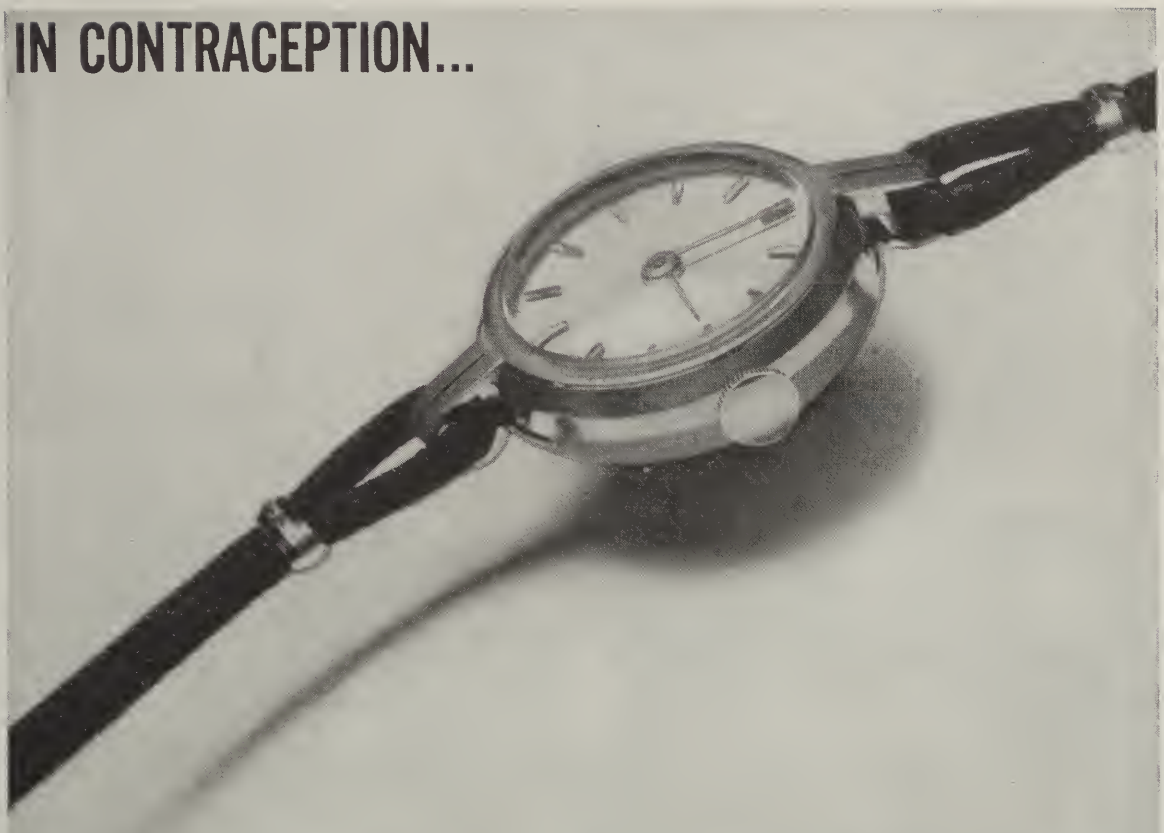
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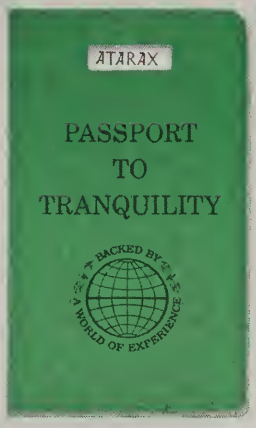
Winkelstein, A.: Am. J. Gastroenterol. *32*:66-70 (July) 1959.

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IN HYPEREMOTIVE ADULTS does not impair mental acuity	"... especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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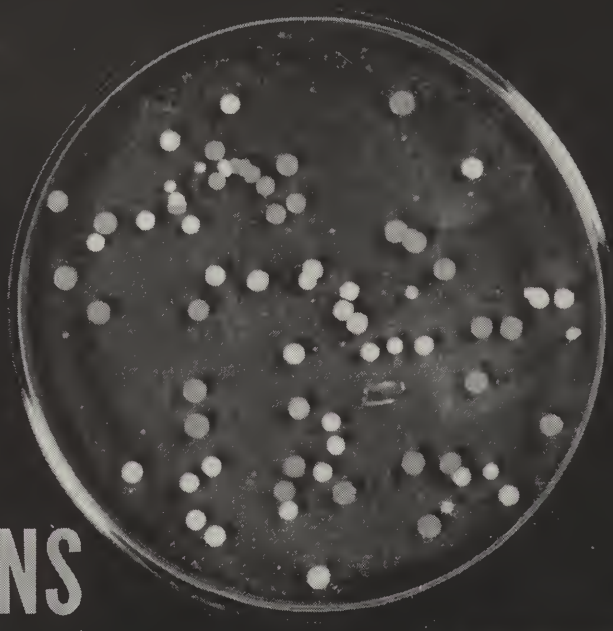
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1. Smith, I. M., and Soderstrom, W. H.: J. A. M. A., *170*:184 (May 9), 1959.

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Detection and Diagnosis Of Early Cervical Cancer

ROBERT E. L. NESBITT, JR., M.D.*

Albany, N. Y.

The general practitioner is the key figure in cancer detection in presumably well persons, and he must know his responsibilities to the public and cancer specialists

THE clinician's basic responsibilities in the over-all problem of cervical cancer include prophylaxis, detection, diagnosis and management. The latter phase, that of definitive workup, therapy and follow-up care of cancer patients, logically should become the principal responsibility of the specialist, but the problem of long-term prophylactic scrutiny and careful screening of patients for cancer is the responsibility of every practicing physician, particularly the generalists who care for a majority of the females in this country.

The uterine cell test of Papanicolaou, which supplements a careful pelvic examination, is the key procedure in meeting this responsibility. Prior to the development of exfoliative cytology, when biopsies were obtained only after symptoms or gross findings were present that led to a suspicion of cancer, early cervical lesions were discovered only occasionally.

It is well known that, in its early stages, cancer of this organ is not usually evidenced by characteristic gross surface change or clinical symptoms. About three-quarters or more of the confirmed cases of carcinoma in-situ occur in cervices that are completely normal in appearance. When there is an easily recognizable gross lesion present in the cervix, it is only common sense to subject it to histological study.

The greatest value of the smear lies in the detection of early cancer unattended by specific target lesions on the cervix. Cytologic smears, especially those obtained by cervical scraping and endocervical aspiration, are significant in that they sample cells from the entire uterine cervix.

Cancers discovered at the pre-invasive stage are curable in essentially all cases by existing techniques of management. It is important, therefore, to educate the medical profession and lay public to the need for routine cytological examination of all women, including obstetrical patients, who are over 20 years of age. It should be possible for every practitioner to have available at least minimal lab-

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oratory equipment, as well as facilities for the procurement of vaginal or cervical smears, to meet the basic requirements for cancer detection.

The need for additional professional educational effort is emphasized, however, by the fact that reliable reports indicate that in the United States less than 5 per cent of the 53 million women over the age of 20 receive the protection of the cervical cytology test.[1]

Concomitant with the rise in number of unselected smears obtained in a community, there is a relative increase in the number of cases of carcinoma in-situ encountered as compared to invasive cancers.[2] Thus, it is apparent that, if this test is to be employed for the detection of cancer in apparently normal individuals, the physician is beset with a new challenge that presupposes a thorough understanding of the significance of hyperactive and in-situ lesions of the cervix. Moreover, he should be able to recognize the predisposing factors of malignancy, the physical signs and symptoms that suggest carcinoma, and possess a knowledge of the methods of positive diagnosis. It is not possible to understand these incipient phases of uterine cancer or to institute effective workup and management without a fundamental understanding of the histopathology.

Detection and Diagnosis

It is important to make a clear distinction between cancer detection and cancer diagnosis. The cytological method should be regarded as an important screening test rather than as a definitive examination for cervical cancer. Cancer diagnostic procedures usually require special training and skill to carry out since they are designed to fit the particular problem and require the removal of tissue for histological study. Histological confirmation of doubtful or positive cytological findings are required before definitive diagnosis or treatment of the lesion is justified.

Schiller's iodine test may be of value in delineating areas that require biopsy. Also, it is mandatory to biopsy any lesion of the cervix, whether or not it is suspicious of cancer, if it is to be treated by cauterization.

The Gaylord punch biopsy forceps is one of the most efficient instruments avaliable for securing a sample of cervical tissue for study, although a variety of cutting instruments will frequently prove equally useful. When tissue obtained by punch biopsy shows carcinoma in-situ, the removal of additional tissue is usually required to exclude the possibility of early invasion elsewhere in the cervix.

A biopsy demonstrating the histological characteristics of carcinoma in-situ may be taken from the periphery of an advanced cervical cancer. This fact demonstrates to us a point that among other things which should be done when one is searching for early cervical lesions is an adequate pelvic examination. It is essential to know first that carcinoma in-situ is present, but one must also know that an invasive carcinoma is not present. The co-existence of carcinoma in-situ and invasive carcinoma is entirely too frequent to be ignored.

It should be recognized, moreover, that carcinoma in-situ lesions may extend to involve a large area without becoming invasive, frequently down onto the vaginal mucosa and occasionally up into the uterus and tubes.[4] Involvement of endocervical glands is common; in fact, most of these lesions arise in this region and as long as the lesion is confined within the gland structure, the diagnosis remains carcinoma in-situ.

The diagnosis of carcinoma in-situ does not demand emergency treatment and, in order to be certain that no invasive areas are missed, we have subjected the great majority of our cases to cervical conization before definitive diagnosis or treatment. We prefer the cold-knife, since then the complete rim of the squamo-columnar junction, including the major portion of the undisturbed endocervical canal, is available, without charring, for as many histological sections as needed. This technique serves not only to prove the presence of carcinoma in-situ, but also shows whether or not, and to what extent, the cervical glands are involved.

Both multiple blocks and serial or step sections of questionable areas should be cut and studied as necessary by a competent pathologist as well as the clinician. One cannot justify the performance of this surgical procedure if the excised tissue is not to be adequately studied.

Pregnancy and Carcinoma

Pregnancy puts certain limitations on the time and frequency of diagnostic procedures and the amount of cervical tissue that can be safely removed for study. However, if the histological criteria for carcinoma in-situ are present, the diagnosis should be made regardless of pregnancy. If no invasion is found upon adequate study of the excised tissue, often obtained by a ring biopsy or shallow cone biopsy, pregnancy is allowed to continue to term and delivery provided meticulous follow-up of the patient is instituted with reexamination of the pelvis at frequent intervals, cytological smears, as indicated, and colposcopy, if available.

It has been our custom to subject all of these patients to a definitive diagnostic procedure at six weeks postpartum, usually by subjecting them to a wide, deep cervical conization.

Histologically, the cellular components of the surface epithelium in carcinoma in-situ of the cervix are identical with those in clinical carcinoma, and the differentiation depends upon the state of the basement membrane rather than on cellular characteristics. Accurate differentiation of these lesions on the basis of exfoliated cells cannot be relied upon.

Moreover, a distinction should be made between carcinoma in-situ and the International Clinical Classification, Stage O. The latter classification is a clinical term used to classify cervical carcinomas unassociated with characteristic gross lesions; thus, this classification includes certain cases of early invasive cancer in which there is no gross lesion which could reasonably be expected to be cancer. Contrariwise, carcinoma in-situ is a histological diagnosis definable as a lesion in which the entire thickness of the squamous epithelial layer is replaced by cells microscopically indistinguishable from those of frank invasive cancer, with the complete loss of stratification, but with no invasive penetration of the basement membrane, either of surface epithelium or of the endocervical glands (Figure 1).

Atypism

Atypism is manifested by individual cells throughout the entire thickness of the epithelial layer which exhibit macronucleosis, macronucleoli, anisonucleosis, and nuclear and cytoplasmic pleomorphism. Irregular and massed

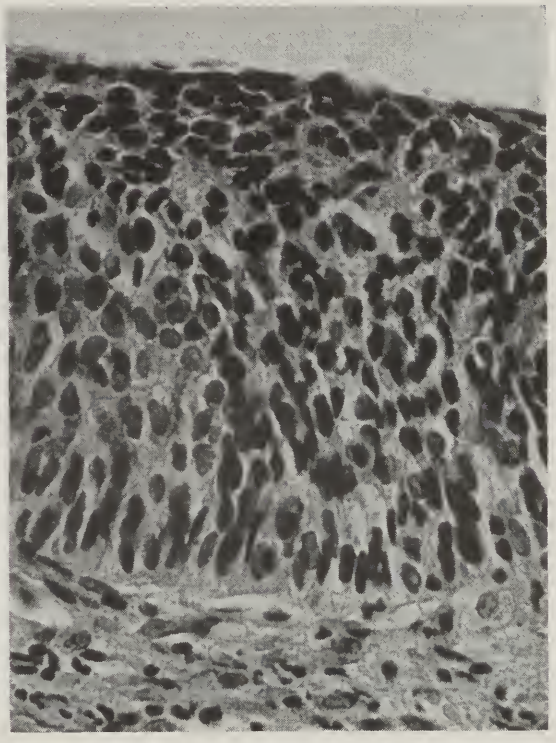


Figure I

Carcinoma in-situ, H & E stain, x285. Note loss of stratification, cellular atypism and hypercellularity from the basement membrane to surface of epithelium. Courtesy of Nesbitt and Stein, Surg., Gynec. & Obst., 107:161-168, (Aug.) 1958.

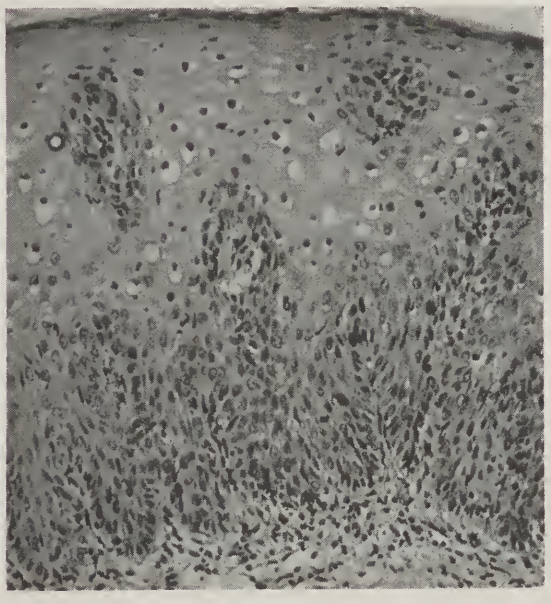


Figure II

Basal cell Hyperactivity, H & E stain, x200. Note hyperactive basal zone with overlying stratification.

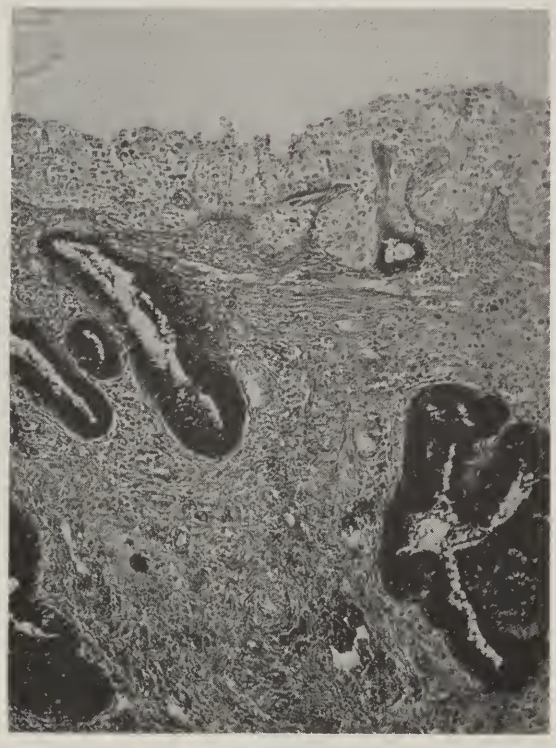


Figure III

Carcinoma In-situ. Periodic Acid-Schiff stain, x130. Entire thickness of surface epithelium is made up of nonstaining basal cells. Note the sharply defined basement membrane. Courtesy of Nesbitt and Stein, Surg., Gynec. & Obst., 107:161-168 (Aug.) 1958.



Figure IV

Carcinoma in-situ with gland involvement, Periodic acid-Schiff stain, x130. Glands subjacent to surface epithelium remain unstained because of immature cells, while deeper normal glands take a heavy stain. Basement membrane of glands is intact.

chromatin clumps may be prominent and lend a basophilic tinctorial effect to the epithelium. Mitotic figures are nearly always increased in number, frequently in the superficial layers. Alterations in polarity of cellular orientation occur when the cells fail to take their normal position and appearance; normal flat squamous cells are not evident in the surface zone.

The importance of differentiating basal cell hyperactivity from carcinoma in-situ has been stressed repeatedly: In cervices showing basal cell hyperactivity, there remains some stratification of squamous cells overlying the hyperactive basal zone. In general, there is uniformity in the appearance of nuclei in benign lesions, polarity is maintained, and the individual cells do not take on the nuclear characteristics previously noted for malignant lesions (Figure II).

The periodic acid-Schiff stain (PAS) is useful in making this distinction.[7] Basal cells of the ectocervix and reserve cells of the endocervix do not take this stain because of low glycogen and mucopolysaccharide content, while the intermediate and superficial cells are heavily stained by this technique. This rather consistent difference in staining qualities can be utilized in determining the extent of basal or reserve cell hyperactivity in cervical epithelium (Figure III).

Moreover, hyperplastic or anaplastic reserve cells appearing in the endocervix do not take the stain and, thus, are readily distinguishable from the ordinary columnar epithelium or squamous metaplasia of the mature type which contain considerable PAS stainable material (Figure IV).

False-positives

A point of special interest to the clinician is the one of the so-called false-positive cytological test which, in our experience, is not false-positive at all in many instances. It is true that in these circumstances, the patient does not have cancer, but she frequently has marked cellular alterations affecting the deeper cell layers but disappearing in the layers nearest the epithelial surface.[5]

In our clinic, there was a 68.5 per cent incidence of basal cell hyperactivity, shown histologically, in 54 patients who had false-positive smears, and 35.6 per cent of the patients with doubtful smears showed basal cell hyperactivity in the biopsy.[6] Only 37 (4.5 per cent) of the 813 cervices shown by the smear to have normal cellular findings showed basal cell hyperactivity histologically.

Experience has shown that the lesion of basal cell hyperactivity, although a reversible process, is highly significant and warrants repeat studies and protracted followup. Likewise, when the cervical smear is persistently positive (class IV), in spite of insignificant findings in tissue obtained by punch biopsy, an energetic diagnostic program is imperative, often including conization of the cervix, fractional curettage of the uterus or even, occasionally, culdoscopy and paracentesis.

Another problem that is of interest to the clinician is the fate of the female patient who has had a cytological examination made and received a negative report. Based on a statistical follow-up for three years and on impressions covering a period of approximately seven years, Schulz and co-workers[9] found that a negative cytological examination, when associated with negative physical findings following a thorough examination of the patient, implies that the patient is free of carcinoma at that time and will remain free of cervical cancer for a period of at least two years. Thus, annual checkups for these patients who are 20 years of age or older constitute a program of cancer detection well within safe limits.

Data now available not only indicate that the false-negative error is low for the first examination, but suggest that the possible error disappears for all practical purposes if women are examined at yearly intervals.[3] This program also points out to patients the desire on the part of her physician not only to cure her when she is ill but to anticipate and try to prevent problems thoughout her entire lifetime.[8]

Summary

In summary, it is important to emphasize that because of genuine concern for pre-invasive cancer and atypical hyperactive lesions of the cervix, routine screening on a periodic basis of all women over age 20 is an integral part of medical care. The cervical smear has taken its place along side the biopsy as part of the standard gynecological armamentarium.

The general practitioner is the key figure in widespread cancer detection programs designed to discover evidence of disease in presumably well and asymptomatic persons, and he must be fully acquainted with his responsibilities to the public as well as to cancer specialists. Prophylaxis and prompt detection become the joint responsibility of every woman and her physician; and if each is alert to this responsibility, cancer of the cervix will cease to be one of the principal causes of death in the female.

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The Practical Application Of Medicine To Jet Transportation*

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Flushing, N. Y.

Certain factors which may influence a medical decision to transport patients by air are presented here. Generally, very few ambulatory persons cannot travel by plane

IN 1939, the certificated airlines of the United State carried 1.8 million passengers. Last year, the number of passengers carried was 49 million. This does not include the many people flying in corporation aircraft or private planes.

Under ordinary circumstances, the airlines do not question one's physical condition; consequently, the accurate number of passengers traveling with illnesses is unknown. Many of these people may be patients of yours under treatment or with some chronic illness. It is only natural for a patient who has some affliction to go to his personal physician when the question of travel arises. Who should or should not fly, then, becomes a problem in your medical practice.

Man was designed to function most efficiently on the earth's surface. He, in his desire for advancement, has found it advantageous to go into the air far above the earth. Since certain conditions are necessary to maintain life, it may be worthwhile to review briefly some physics of the atmosphere.

Physics and Physiology

Of the elements making up the atmosphere, oxygen is the most important to man. Regardless of the altitude, the amount of oxygen in the atmosphere remains constant at 20.9%. At different altitudes above sea level, it is the pressure that varies and not the percentage of oxygen. Under normal circumstances, we live quite well at sea level under a pressure of 14.7 psi or 760 mm Hg. The partial pressure of oxygen at sea level is 159 mm Hg. The significance of atmospheric pressure is more easily understood if we consider that the exchange of gas between the body and the environment is accomplished by diffusion which follows certain physical laws.

In a mixture of gases, such as the atmosphere, the partial pressure exerted by each individual gas is the same as it would provide if it were the only gas present. The total pressure of the mixture is equal to the sum of the partial pressures of gas and water vapor present in the mixture—this is Dalton's Law. When a liquid is exposed to a gas mixture, diffusion takes place whereby the amount of each gas absorbed depends upon its partial pressure. This is Henry's Law. In the application of these two laws to the human being, we find that he is capable of adjusting physiologically to an altitude of 10,000 feet. Above this point, he is no longer able to compensate and the efficiency of his respiratory system is impaired.

At 10,000 feet, the arterial oxygen saturation of the blood is about 90%. At 15,000 feet, oxygen saturation drops to 81%, and if maintained for a sufficient length of time results in drowsiness, headache, cyanosis, impaired vision

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**Medical Director, American Airlines, Inc.

and judgment and certain personality changes. At 22,000 feet, the oxygen saturation drops to 68% and convulsions may occur. If one remains at 25,000 feet for a period of about five minutes, the oxygen saturation drops to 55-60%, and will cause unconsciousnsess.

Because of this, it was necessary to develop some system which would permit the passenger to fly in comfort irrespective of the altitude of the airplane. Until 1948, this was done by providing passengers with supplemental oxygen. If the airplane flew above 10,000 feet for an appreciable length of time, the idea was to provide a sufficient quantity of oxygen to make up for the decreased blood saturation, which was due to the lowered atmospheric pressure. While this method was satisfactory, if you remained in your seat, it was impossible to use the oxygen mask and to move about in the airplane, and wearing the mask for prolonged periods was quite uncomfortable. Furthermore, it is physiologically impossible to maintain an adequate arterial oxygen saturation above 34,000 feet even though the individual is breathing 100% oxygen.

Cabin Pressurization

During World War II, the military services developed the pressurized cabin. This cabin pressurization is the production of a pressure equivalent to a lower altitude by the compression of ambient air in the cabin. This, in effect, is taking a can of atmospheric pressure at some lower altitude that you like, and taking it up to a higher altitude to use where you need it.

The pressurization of airplanes has rapidly improved so that today in the most modern jet airliners, such as the Boeing 707, the pressure differential is 8.6 psi. As a result, it is possible in this plane to maintain a cabin altitude of sea level when the ambient altitude is 22,500 feet, or a cabin altitude of 5,500 feet when the ambient altitude is 35,000 feet. The Lockheed Electra, with a pressure differential of 6.55 psi, maintains a cabin altitude of sea level at 15,000 feet. The Fairchild F27, also being used in this part of the United States, maintains a sea level altitude when it is flying at 10,000 feet.

There are still some commercial planes flying that are non-pressurized. However, their number is being rapidly replaced by pressurized aircraft. From a medical standpoint it is important to know that there is a varying pressure differential and that this pressure differential itself may vary with different makes of aircraft.

It is well to note at this time that although most of the airplanes now in operation are pressurized, they carry a supply of oxygen which may be used if the pressurization system malfunctions or if someone is ill and needs a little oxygen to support him. It should be pointed out, however, that the oxygen on the airplane (as required by law) is supplemental in quantity and not therapeutic.

Before discussing specific medical conditions, it would be well to mention some important features in airplane travel which might influence a decision concerning potential passengers.

In the Continental United States, where excellent medical facilities are available, severely ill patients are rarely moved by air. However, in some sparsely settled areas of the world, where airplanes are the only fast medium of travel, the airline companies make provisions in emergencies. Some of the airlines in the U. S. serving cities with large medical centers, do make special provisions for carrying patients. Different airlines have different rules that cover items such as loading and unloading, care on board, and the use of accompanying attendants. Because of these varieties of policy of the different companies, it may be wise to check with the potential carrier.

Very few diseases per se are a contraindication to air transportation. The question really is can they be moved by any method of transportation. Frequently the question is one of hospitalization and not transportation, but in our discussions we often tend to forget this fact.

Important Symptomatology

In many diseases, there are certain signs or symptoms whose presence or degree may affect a decision as to whether or not a patient may fly. One of the most common of these is pain. The degree attached to its importance is sometimes doubtful; however, on occasion it can be diagnostic. Chest pain may arise from three sources—the chest wall, intrathoracic and intra-

abdominal organs. One of the most important causes of pain is heart disease.

Because of its interference with respiration, the presence of edema is an important sign. Edema may be intra or extra cellular. It is the extra-cellular or the fluid in the body cavities that is of special importance to us because it may denote cardiac failure or produce cardio-pulmonary embarrassment.

Dyspnea is the subjective phenomenon of difficult or labored respiration. To the physician it is an important symptom and a sign of diminished pulmonary function.

Anoxia, or the newer term hypoxia, because of the improved pressurization systems, is no longer the problem it was prior to pressurization. It will play little part in medical problems unless disease is present of such a nature to cause a marked reduction of the oxygen arterial saturation.

The anemias may also play a part. Regardless of the many ways they can be classified, the common factor is a reduction in the ability to carry oxygen and its distribution to the body cells.

Lowered Oxygen Tension

Cyanosis is due to conditions in which there is a lowered oxygen tension, or abnormal types of hemoglobin. It is well to remember that individuals may have lowered oxygen tension without any evidence of cyanosis in the presence of anemia. Cyanosis is a definite, important sign in evaluating a patient's capabilities.

In addition to these physiological or pathological signs, there are certain other items of importance which should be considered in evaluating a patient's ability to travel. Foremost, and first, of course, is the necessity or the desirability of making the trip. Sometimes ill patients may be disturbing to the other passengers because of the limited space which eliminates a considerable degree of privacy for the patient. Is the plane pressurized? There are some planes that still are not. How much oxygen will the patient need? If any extra supply is needed, individual tanks may be rented. Some patients should be accompanied by attendants and provisions made to assist them in getting on and off the plane.

Specific Diseases

The most prominent heart disease today is coronary artery disease. This is also true in respect to passengers. However, actual experience in air travel has been very good. Passengers with myocardial infarction may fly if the attack is more than six weeks old, although some physicians prefer a little longer period, depending on the case. The patient should show no signs of pain, dyspnea or cyanosis, and the electrocardiogram should have stabilized. The patient should be in the stage when mild exercise is permitted. If a patient is able to climb a short flight of stairs, or walk two or three blocks, he is capable of flying in a pressurized plane.

Cases of angina pectoris are acceptable if attacks are not present at rest. If an attack occurs on the plane, airline personnel will provide oxygen from the airplane's supply, but it should be remembered that, as previously stated, this is supplemental rather than therapeutic in quantity. As on all other occasions, patients should have nitroglycerin readily available.

Cases of hypertensive cardiovascular disease do very well in flight. However, anyone with prodromal symptoms of stroke or evidence of decompensation should not fly. Patients with congenital heart disease without symptoms may fly without any difficulty. Those cases with symptoms should be individually evaluated. Valvular heart disease is acceptable, if the disease is quiescent, and there is no cyanosis, dyspnea or other evidence of failure.

Of the arrhythmias, the occasional extra systole is no problem. Paroxysmal supraventricular tachycardias with little dyspnea, and in the absence of organic heart disease, present little difficulty. Atrial flutter and fibrillation are much more disturbing and the physician should consider the necessity for the trip and then make a cardiac evaluation. Heartblock should be evaluated in respect to the underlying disease. Many cases of AV block and bundle branch block fly without any difficulty. Wolfe-Parkinson-White syndrome is no contraindication, although complete heart block (Stokes Adams syndrome) is.

Asthmatics fly in comfort between acute attacks. Cases of emphysema do poorly as air passengers. Cases of foreign body in the lung

may be transported if there is no edema, and the patient is covered by oxygen.

Odors readily permeate the airplane and are objectionable to the other passengers. In cases of neoplasm, bronchiectasis and abscesses, consideration must be given to others if the patient is raising sputum. In the absence of foul sputum and with no marked decrease in pulmonary reserve, the patient may be considered for flying. Dyspnea on slight exertion should rule out air transportation.

Active cases of tuberculosis are not carried in the U.S. due to public health rules. Arrested cases present no problem. Patients with a pneumothorax should not fly because of exposure to the pressure changes. Post-operative chest cases generally do quite well, provided the lesion is healed. Lobectomy and pneumonectomy cases do not travel well under three months after the operation. They can fly in pressurized airplanes if the mediastinum has become fixed. Passengers with tracheotomy should advise the airline so that arrangements can be made to change the oxygen mask.

Anemic Patients

Anemic patients in general do very well provided the hemoglobin is above 60%. Some physicians have recommended a red blood count of over three million. Patients with leukemia may fly if their general condition is good. They should have a transfusion before flight and an independent oxygen supply available.

Several recent reports have indicated that sickle cell crises have occurred in patients while in flight at both relatively low and high altitudes. There is considerable evidence to indicate that when sicklemia cases are exposed to decreased oxygen tension, splenic infarction may occur. Any suspected case of this disease should be tested to rule out its presence before flight.

Diabetics may fly without difficulty provided they will need no insulin en route, or they should be capable of administering it themselves. They should be warned not to pack their insulin and syringe in checked luggage, since it will be inaccessible in flight. Diabetics subject to motion sickness should take one of the several anti-motion sickness drugs available.

Psychotic cases who are dangerous or obnoxious should not be permitted to fly. Any neurologic disease should be ambulatory and have full bowel and bladder control.

Convalescing post-operative abdominal cases can be accepted provided 10 days to two weeks have elapsed since the initial surgery, there is no drainage, and the abdominal wall is closed. Passengers with very large unsupported hernias may be subjected to an increased abdominal pressure, which could produce a strangulation, and therefore, should not fly. Care must be taken with patients with colostomy bags. Because of the restricted cabin space, they should be non-odorous and they should be emptied just before flight.

Uncomplicated peptic ulcer cases do very well in flight provided there is no possibility of perforation.

Newborn infants do very well as passengers if they are more than 10 days old. Apparently under this age the respiratory system has not stabilized adequately to cope with pressure changes. Pregnant passengers may be flown without any difficulty within the first eight months of pregnancy provided there is no past history of premature birth or abortion. The presence of toxemia requires further evaluation. Cases of pregnancy may be flown during the last month provided it is a short flight (time-wise) and the obstetrician will furnish a statement that in his opinion the individual is not due to deliver within 72 hours of the proposed destination time.

Public Health Problem

Jet transportation, because of its speed, has created a definite public health problem. It is possible to travel from the Orient or Africa before the completion of the incubation period of all of the major contagious diseases. Because of this, there is no way that these diseases can be recognized as the passengers pass through health inspections at ports of entry. It certainly is within the realm of probability that we may see tropical diseases, ordinarily not seen in this country, and future history taking will include a more detailed record of travel.

Conclusions

1. There are certain factors inherent in air transportation which may influence a

medical decision to transport a patient or a passenger by air.

2. There also are certain signs or symptoms which are important and may influence the decision.
3. Generally, most patients may travel by air if they are able to travel at all.
4. Some patients may travel with medical support.
5. Only a few should not travel at all.
6. International jet travel has introduced a new public health problem and diseases considered foreign to this country in the past may begin to appear.

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Acute Renal Failure*

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The types and causes of acute renal failure, with their basic pathologic and biochemical aspects, are discussed. Fundamental principles of therapy are outlined

THERE is nothing more startling to man than anuria. The first reaction of the physician, the patient and the family is that something dramatic and drastic must be done. This approach may be fatal. Instead a well-calculated investigation must be promptly initiated to demonstrate the cause. Curative therapy can be based only upon facts. It is the purpose of this paper to discuss briefly the mechanism and the fundamental considerations in the diagnosis and treatment of acute renal failure.

Causes

Acute renal failure is either reversible or irreversible. Furthermore, renal failure may be caused by disturbances in any of three areas in the body: (1) pre-renal, (2) renal and (3) post-renal. Pre-renal factors causing anuria include circulatory disturbances, dehydration and electrolyte imbalance. Correction of these factors in their incipiency is most often rewarded with prompt improvement and complete recovery. Reversible acute renal failure of renal origin is most often occasioned by chemical poisons (i.e., carbon tetrachloride, mercuric chloride, etc.), severe shock and transfusion reactions. Post-renal causes include vesical neck or urethral obstructions or diseases which obstruct both ureters, such as carcinoma of the prostate with ureteral occlusion, etc. These conditions demand operative interference which permit removal or by-passing the obstruction.

Characteristically the urine in acute renal failure is acid containing a variable number of red blood cells, leucocytes, hyaline, granular and cellular casts. Proteinuria is always present and persists for a variable period following recovery. However, as renal function returns, the urine approaches normal and after a period of months usually returns to normal, microscopically and chemically. Nevertheless, the actual renal function remains below the lower limits of normal as demonstrated by thiosulfate, creatinine, para-hippurate and urea clearance tests.[13,14]

Treatment Principles

The treatment of acute reversible renal failure resolves itself in reducing to a minimum the following:

a. Metabolic abnormalities
b. Electrolyte imbalance
c. Azotemia
d. Hyperpotassemia
e. Overhydration

To prevent or reduce to a minimum the above undesirable extracellular conditions, one must avoid or reduce to a minimum protein catabolism, avoid potassium ingestion (beef broth and orange juice are particularly high in potassium) and provide the necessary caloric intake by means of carbohydrate and fat.

Acute reversible renal failure, when not superimposed upon chronic renal disease, irrespective of cause (ie., shock, transfusion reaction, chemical poisons, etc.) presents basically

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the same intrarenal picture. There is present gross tubular dysfunction associated with markedly diminished renal blood flow. The glomerular filtrate is proportional to the blood flow and it is reabsorbed unaltered into the blood stream through the damaged tubules.[12] The reduced renal blood flow and glomerular filtration rate accompanying severe surgical shock, for example, are usually much greater than the associated fall in the peripheral arterial pressure. There is an active and specific renal vaso-constriction.[10] Furthermore, even though the peripheral blood volume is replaced by transfusion, the renal blood flow either does not increase or does so only temporarily. It is the diminution of renal blood flow that is responsible for all the abnormalities of renal function that follow.[4,9,19,20] In spite of the fact that the process may be reversible, the resumption of normal renal blood flow is gradual, requiring a period of three to nine months from the onset of renal failure to reach maximal improvement.[13,14]

Tubular Functions

Originally it was considered that the mechanical blockage by precipitates in the renal tubules caused anuria.[1] However, there is no correlation between the degree of apparent tubular blockage and the severity of oliguria.[5] Furthermore, the anuria due to the intrarenal shunt described by Trueta[23] is unlikely in view of the high renal arteriovenous oxygen difference and grossly reduced renal blood flow characteristic of acute renal failure.[4,8,9]

The ability to concentrate waste products in the urine is one, but not the most important tubular function. Normally the renal tubules possess the ability to secrete urea or creatinine in urine 100 or more times the concomitant concentration in the plasma. However, in acute renal failure, this ability of concentration is lost and the U/P ratio approaches 1 or less.[4,11,15] In addition, the ability of the tubule to conserve electrolytes is lost as in the instance of urea or creatinine concentration. This does not improve proportionately with the onset of diuresis. In fact, during the post-acute period of renal failure the patient risk is unaltered until the U/P concentration ratios of urea and creatinine return to 10:1 and 20:1 respectively and the P/U concentration ratios of sodium and chloride return to 5:1.[4] It is the re-establishment of renal tubular function upon which the life of the patient depends.

During the oliguric or anuric phase of acute renal failure there is a progressive azotemia occasioned by tissue breakdown. Azotemia continues through early diuresis while the kidney now enthusiastically excretes water though its powers of concentration are still faulty. It cannot rid the body of sufficient urea, creatinine or uric acid to keep ahead of metabolic accumulation. Also, at this time, potassium may be suddenly spilled into the extracellular fluid so that a dangerous and precipitous hyperkalemia may occur.[22]

Furthermore, during the oliguric or anuric phase the tissue catabolism and renal inability to excrete the H^+ results in a metabolic acidosis which persists for a variable period following diuresis. Tissue catabolism and particularly that of fat permits an increase in body water which in turn relatively reduces the plasma concentration of sodium and chloride.[10,22] However, in spite of an increased total exchangeable sodium, the exchangeable potassium is diminished even in instances of marked hyponatremia and hyperkalemia.[16] These factors are of prime therapeutic importance in electrolyte considerations during and following the anuric phase.

Treatment

The treatment of acute renal failure demands an accurate diagnosis which depends upon a painstaking history supplemented by a thorough search for obstructive uropathy by cystoscopy. If an obstructive factor has been eliminated and the condition found to be an acute failure of strictly renal origin, the treatment must encompass certain consideration.

Primarily the treatment of acute renal failure resolves itself into reducing to a minimum the metabolic consequences. It is desirable to minimize the accumulation of potassium and nitrogenous products in the blood, to avoid overhydration and maintain as near normal as possible the electrolyte pattern. To attain these objectives it is necessary to avoid protein catabolism, to avoid potassium ingestion and provide calories by means of carbohydrates and fat. This nauseating diet is avoided by the use of continuous intragastric drip of 1000 cc. of peanut-oil-carbohydrate emulsion which provides 2500 calories and replaces the insensible

fluid loss.[3] After the anuric phase subsides and the urine output exceeds 1000 cc. daily, a low protein diet is permitted.[3]

The daily fluid volume of 1000 cc. is considered excesive by some[2,6,7,17,21] and it has been advocated that the caloric replacement of 400 grams of glucose per day be accomplished with 800 cc. of 50 per cent glucose given by a continuous drip through a catheter introduced into the vena cava through the saphenous vein.[17,18] This should be supplemented with insulin (10 to 20 units three times daily) to afford additional glycogen formation and glycogen-potassium complex within the cell, which prevents extracellular hyperkalemia. The use of testosterone (25 mgm. daily) acts as an anabolic agent. Also, in the face of hypercalcemia, prednisone 5 mgm. four times daily has been found helpful and is reduced according to the results of future calcium determinations of the blood.[16]

Use of Salt Contraindicated

The use of any salt-containing fluid during the anuric phase of acute renal failure is contraindicated since the total body sodium is increased already, and the use of salt-containing fluid will promote either water logging and pulmonary edema or will increase the loss of essential electrolytes during the diuretic phase by exacerbating the osmotic diuresis which occurs naturally at that time.

Dialysis, or the so-called artifical kidney, has its place when the electrolyte pattern has been permitted to deteriorate to a point beyond metablic help. It cannot be denied that the homeostatic function of the artifical kidney has its place, but the simplicity of these fundamental methods provides an opportunity for restoration of function without the hazards of mechanical separation of extracellular electrolytes. Dialysis is not the answer that it is often considered; it is but a single adjunct in the treatment of renal failure and has its undeniable limitations and risks. It is far better from the onset to minimize catabolism, to favorably influence cellular metabolism and shed potassium and hydrogen ion into the extracellular fluid by preventing or at least controlling the increase total body water and sodium that inevitably occurs.

Summary

The basic principles involved in the treatment of acute renal failure are discussed along with the fundamental pathology and biochemical aspects. The importance of caution and carefully considered therapy in actue renal failure is stressed.

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The Care of Patients With Multiple Injuries*

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Principles in caring for a person with wounds involving several systems are recalled. The physician should be forearmed with specific plan of evaluation

FARM, home, industrial and traffic accidents are frequently important in the practice of medicine. In view of the increasing incidence of massive injuries from mismanaged high velocity vehicles, and considering the potential extent of destruction of human bodies with presently available weapons, more than ever our obligations include preparation for the care of these injuries. We are confronted with the duty of leadership in educational programs in first aid and emergency care and with the development within our own profession of definite familiarity and facility with the principles and techniques of management of patients subjected to trauma. It is frequently assumed by the general public that a physician is automatically prepared to deal with such situations. Such is not always the case, and the efforts of various groups, including The American College of Surgeons Trauma Committees, are directed toward this problem.

Multiple injuries to individuals and the mass injuries to groups of individuals may occur more frequently in the future. We must learn to recognize priorities of the various needs of these injured patients and specific techniques in their care. While acknowledging with practical candor the deficiencies in our own knowledge and the restrictions on the help which we may offer, it is, nevertheless, incumbent upon us that we continue to seek better means for handling these patients.

Not all such injuries are seen where specialized care is available. Often these problems are met by the general practitioner without an immediately available consultation. It is in his early management that the ultimate fate of the patient may be determined.

In patients with multiple wounds or in several patients severely injured, it may be difficult to know the priority as to management of persons or of injured parts.

The following discussion is presented to bring to attention again certain elementary principles. Although well known and well founded, these basic points might occasionally be overlooked in the haste of emergency situations. Perhaps some are unknown to the physician who rarely handles traumatic cases or neglected as unimportant by even the experienced surgeon.

Prompt Action Important

It must be recognized that while it will be impossible to prevent many of the changes or to alter definitely the course of reaction of injured parts, prompt and definitive action by the physician in earliest attendance on the patient will often eliminate, or, at least minimize, the degree of damage.

The suggestions embodied in this paper are not intended as rigid rules but are indicated as basic principles of care, to be used flexibly in application to specific needs.

By the time the patient reaches the accident room, usually he will have been managed or mismanaged by other individuals present at the scene of the accident or transporting him to the location of definitive care. The best specialists in any field may be unable to counteract the effects of additional injuries which may be

*Presented at a meeting of the Kentucky Chapter, American College of Surgeons during the 1958 Annual Meeting of KSMA.

inflicted by well meaning but untrained assistants in early minutes of the emergency. We must be sure that every phase of the patient's care, examination and treatment is accomplished with the least possible additional trauma. Here again we must point to our obligation for encouraging the education of every possible individual in the simple basic principles of first aid care upon which many times the function and even the life of the individual may depend.

Examination Of the Patient

The circumstances in which the physician first meets the patient may restrict or enhance his opportunity for effective management. These circumstances will include, of course, his environment and physical equipment. Of great importance will be his ability to assess the injury and to plan and execute a reasonable program of management. His initial examination must be as rapid and as thorough as possible. Frequently, initiation of treatment must be simultaneous with obtaining information if the patient is to be preserved.

Immediate attention must be turned toward those injuries which relate to obstruction to free air exchange, to loss of blood, and to shock.

Minute, detailed, historical facts may not be available at once from a severely injured patient or from his associates. However, as soon as his state of consciousness or the story of witnesses will permit, the mode of the accident, the observed injuries to the patient, his subsequent condition and behavior, and any treatment rendered prior to the physician's care should be known. Advantage must be taken of even transient periods of lucidity to obtain such facts as recalled by the patient. Knowledge of general orientation, motor activity, and behavior patterns may assist in the evaluation of the patient's present state. The patient's past history of pre-existing illness, defects and idiosyncrasies is most important in evaluating his condition, or his progress, or in planning treatment.

An initial examination should be carried out systematically and as thoroughly as possible and it should be repeated, at least in parts, in order to ascertain the patient's continuing reaction to his injury. During the time of observation and treatment, movement of the patient should be kept at a minimum and significant findings both as to history, physical examination and treatments rendered should be recorded and readily available in prominent records. It is here that the so-called "disaster tags" find useful applications.

Priority Of Management

High in priority lists for effective patient management is the problem of asphyxia. This may be from direct obstruction, compression of the lungs, or diminished thoracic expansion because of rib-cage instability or from suppression of cardiac activity by tamponade. Oral airway with an endotracheal tube or simple tongue holder may suffice, but tracheostomy will often be found the easiest and most certain. Tracheostomy poses few difficulties to those familiar with the technique of its performance. This maneuver is frequently necessary under circumstances in which delay for a specialist in the field would be fatal. Even poorly done, but effectively open tracheostomy is of more value to a distressed patient than an artistically performed procedure on a moribund patient. Such procedure may add a vital 100 cc. volume to an embarrassed respiratory reserve and will furnish a readily available stoma for mechanical clearing of the tracheo-bronchial tree. Aspiration through the chest wall for tension pneumothorax or for hemothorax may be life-saving. Stabilization of the flail chest wall should be accomplished by compression bandages or by external traction-fixation devices. Pericardial aspiration may be necessary when tamponade is present.

Surface Hemorrhage

Surface hemorrhage must also be controlled, usually by direct pressure or clamping of vessels and/or elevation of the part. A tourniquet is rarely needed and requires most careful application when used. Frequently quoted admonitions for the periodic release of a tourniquet in the interest of prevention of gangrene of the extremity will usually serve no end other than the repeated loss of blood. A tourniquet, if used, should usually be kept in position until the area is ready for definitive treatment.

When hemorrhage within the abdomen or chest persists, this may be made known only

through the failure of the patients to respond to usually adequate amounts of blood calculated on the basis of estimated loss.

Whole blood must be available for loss already incurred and for anticipated loss from the wound or from operation. Serum albumin, plasma and plasma volume expanders may also be used as adjuncts in restoration of volume or as stop-gap measures until blood is available. Fluids such as Dextran are probably the most desirable of these. Time should not be wasted in searching for a vein for needling. Direct "cut down" and insertion of a plastic intravenous cannula will allow better and prolonged administration of fluids.

Simple Adjunctive Measures

Simple adjunctive measures must be recalled, such as face-down or head-down positions in patients vomiting or in shock, although such position might be contraindicated in those patients with extensive intrathoracic and intracranial injuries. Splinting of the injured part is a most useful factor in the prevention of further shock. The administration of supplemental oxygen may help if cyanosis is present or anticipated. It should be kept in mind that certain injuries, such as femur fractures, may be expected to produce shock and preparation for such should be made. Hypotension measurable by the sphygmomanometer may be a late indication of shock. Anticipation and preventive treatment may effectively forestall severe circulatory collapse.

General principles involving soft tissue surface injuries include several points. All wounds are contaminated. If the general condition of the patient permits, surface wounds should be washed with running water, their edges scrubbed with soap or detergent and antiseptics applied to skin edges but never to the wounds themselves. Adequate debridement, irrigation and closure are then carried out.

Booster doses of tetanus toxoid to previously immunized patients or adequate amounts of tetanus antitoxin should be given. The effective amount of tetanus antitoxin is variously estimated from 1,500 to 10,000 units. It has been shown that tetanus booster immunizations may be effective when given even 10 years after completion of the primary series and initial booster.

The effectiveness of gas-gangrene antitoxin has been closely questioned and, by some, vigorously denied. However, in the face of massive injury to muscle tissue, if there is no allergy to the antitoxin, it may add an additional measure of security. Frequent, repeated observation of extensive wounds must be made to recognize the earliest signs of gas bacillus or other significant infection in order that vigorous therapy may be timely.

Antibiotic prophylaxis is a prominent part of open wound management. It should never substitute for adequate surgical measures of debridement and cleansing or for adequate sterile technique. In this era of frequent antibiotic sensitivities, it is important to obtain a history of allergies to drugs if possible. If such cannot be determined, use of broad spectrum antibiotics may be best while specific antibiotic needs are being evaluated.

Pain will vary according to the type and extent of the injuries and according to the patient's state of consciousness. States of mild shock may result partially because of pain. Judicious use of analgesics and opiates may be necessary. Synthetic narcotics such as Demerol® or Levo Dromeran® may be best. Intravenous administrations of minimal amounts are preferable when peripheral circulation is wavering.

Thoracic Injuries

The management of chest injuries, whether penetrating or not penetrating, must be based upon recognition of the physiology of the thorax and its contained viscera. Immediate conversion of the open pneumothorax to closed pneumothorax is mandatory. Subsequent thoracentesis may be necessary to remove air or blood. Continuing partial obstruction of the airway may necessitate tracheal aspiration or bronchoscopy. It should be remembered that apparent dyspnea may reflect the patient's pain or a low circulating blood volume. Splinting of the chest wall by compression bandages or by external fixation devices may effectively assist the general management of the patient.

After initial stabilization of the mechanics of respiration, attention to further problems of thoracic injury must be developed. Formal wound debridement and/or thoracotomy may be necessary. Intercostal nerve blocks are help-

ful in pain control. The control of infection often depends upon antibiotics in addition to the above measures.

The so-called "steering wheel injuries" may produce myocardial contusion or embarrassment of heart activity by blood filling the pericardial sac. Pericardicentesis for tamponade or open thoracotomy for suture of a heart wound may be necessary.

Most chest wounds will not require thoracotomy immediately, but this may be necessary for deeper wounds and for continued hemorrhage. Later problems of lung re-expansion and of infection are beyond the scope of this brief paper and have been most adequately presented by other essayists.

Orthopedic Injuries

The extent of the force injuring the patient may be indicated to some extent by the type and severity of fractures. The patient's general condition may be stabilized only after immobilization of these fractures or dislocations. In general, reduction should be carried out as soon as possible, depending upon the patient's general condition and, if at all possible, before the inevitable progressive pathologic changes have become well fixed about the site of fracture. Reduction before swelling and induration of the tissues prevent adequate reduction is highly desirable. Complete and accurate reductions with as little trauma to the involved extremity as possible should be accomplished. Splinting even before reduction is necessary. It should be noted here that, in general, our efforts must be conscientiously directed toward the restoration of accurate alignment. In children, however, the natural tendency of this age group to overcome deformities may compensate for some of our deficiencies in reduction.

It is of greatest importance that, after reduction of fracture, casts, extremities, traction devices and alignment be inspected at frequent intervals to achieve optimum results.

Abdominal Wounds

An adequate history from the recollection of the patient or witnesses' description of the mode of injury may indicate the need for abdominal exploration. The early diagnosis of intra-abdominal injury from a non-penetrating wound may pose difficult problems.

Of importance in diagnosis is the failure of the patient in shock to respond to blood restoration calculated from the estimates of visible blood loss, as mentioned before.

The diagnostic abdominal tap is said to offer a rapid clue when the external examination fails to reveal enough information. Initial abdominal paracentesis for diagnosis may be negative and delayed hemorrhage may be found 24 hours later. Blood, bile or fecal material, recovered by needle, may indicate specific types of injury. Multiple quadrant taps may be useful.

Of particular importance is the development of the silent abdomen after previously normally audible bowel sounds. Decision for immediate laparotomy is often based in part upon this finding. The penetrating abdominal wound frequently involves multiple organs and demands exploration when diagnosed.

When signs suggest intra-abdominal injury, x-ray studies for free air may reveal conclusive evidence upon which to base decision for laparotomy.

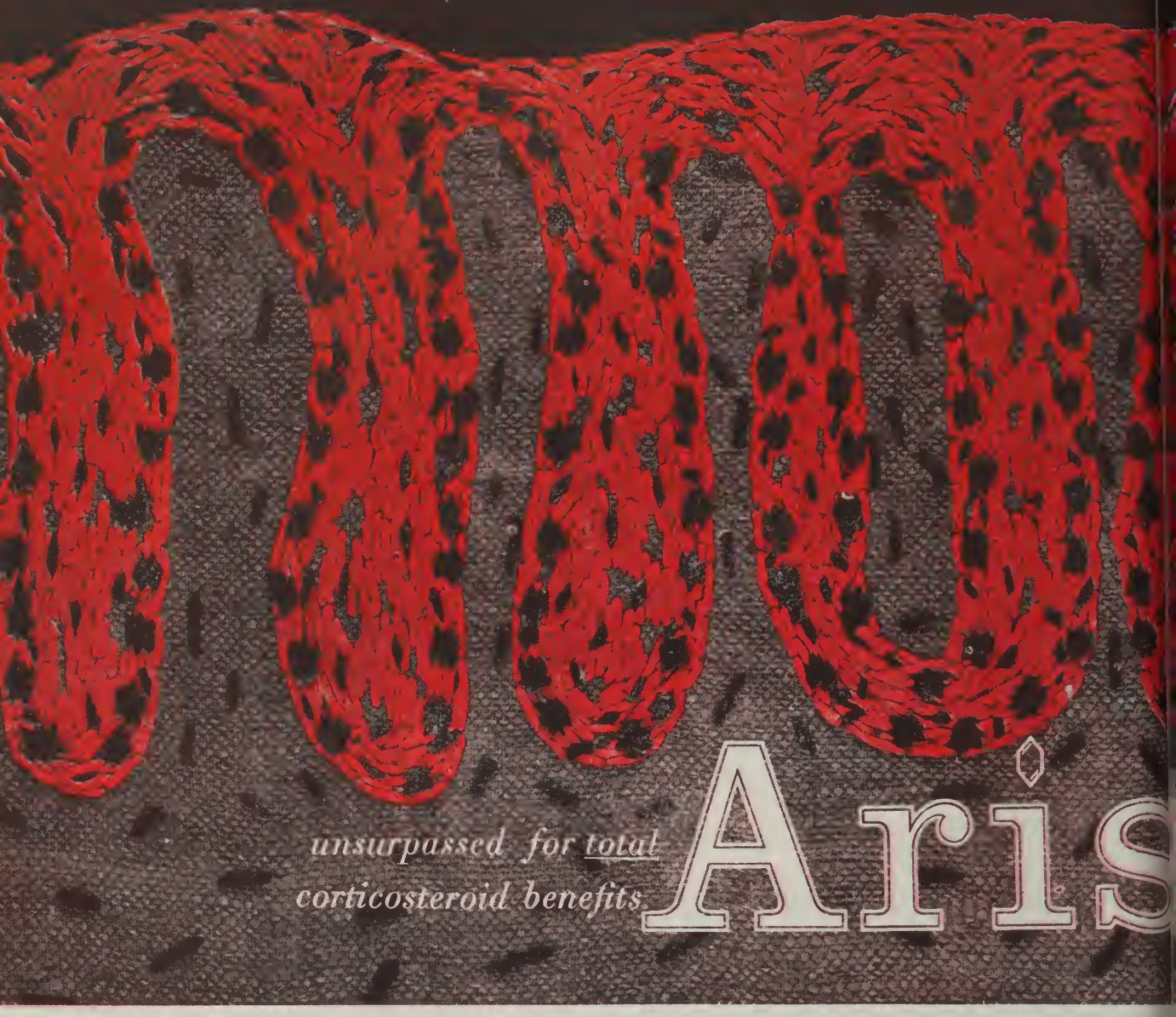
All wounds of the small bowel and stomach should be closed. Many wounds of the large bowel are better exteriorized. In some instances, where contamination is minimal, blood supply is good and closure is without tension, primary closure is desirable. Rectal wounds should be closed and a proximal colostomy performed in most instances. Contaminated retroperitoneal spaces should be drained. An injured spleen must be removed and not repaired. Liver and pancreas should be repaired and drained. Lacerations of the diaphragm must be sought and closed. All injuries to the gastro-intestinal system will require nasogastric drainage.

Urologic Injury

Renal trauma, rarely occurring as an isolated injury, often declares itself by gross hematuria. Hemorrhage into the contused or mildly lacerated kidney seems to be limited by the capsule and fascia. In general, surgical approach to renal contusions is unnecessary. The kidney that requires a surgical approach following injury usually requires removal. Most renal injuries subside without surgery.

It is well known that the bladder is more

in allergic and inflammatory skin disorders (including psoriasis)



unsurpassed for total corticosteroid benefits

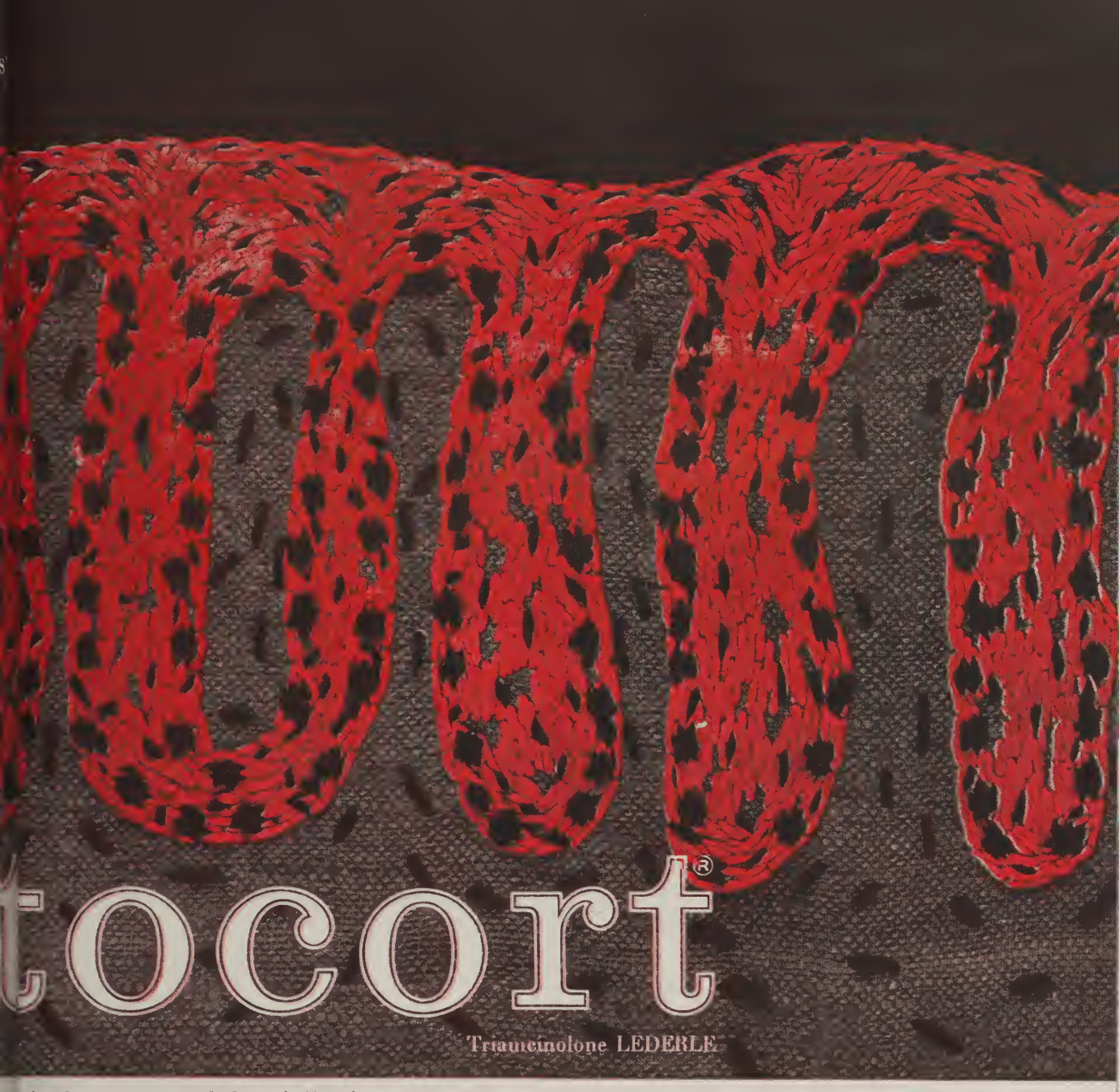
Aris

Substantiated by published reports of leading clinicians

- **effective control** of allergic and inflammatory symptoms[1-3,7,8,12-15,17,18]



- **minimal disturbance** of the patient's chemical and psychic balance[1,4-18]



At the recommended antiallergic and anti-inflammatory dosage levels, ARISTOCORT means:

- **freedom from salt and water retention**
- **virtual freedom from potassium depletion**
- **negligible calcium depletion**
- **euphoria and depression rare**
- **no voracious appetite — no excessive weight gain**
- **low incidence of peptic ulcer**
- **low incidence of osteoporosis with compression fracture**

Precautions: With ARISTOCORT all traditional precautions to corticosteroid therapy should be observed. Dosage should always be carefully adjusted to the smallest amount which will suppress symptoms.

After patients have been on steroids for prolonged periods, discontinuance must be carried out gradually over a period of as much as several weeks.

Supplied: 1 mg. scored tablets (yellow); 2 mg. scored tablets (pink); 4 mg. scored tablets (white); 16 mg. scored tablets (white).

Diacetate Parenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

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Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

vulnerable to blows in the lower abdomen when full. Most bladder trauma is related to damage of the pelvic bones. Bladder injury may be recognized by blood in the urethra, by pelvic pain, and by lower abdominal tenderness, and possibly by muscular rigidity. Rectal examination for hematoma and displaced prostate should precede attempts at catheterization. The Foley type catheter should be inserted for bladder decompression and urethral splinting, and to provide another means for evaluating the patient's condition. This may also yield information of pre-existing disease such as diabetes.

The type and volume of urinary output will modify or indicate further therapeutic measures.

Neurologic Injuries

A large percentage of the deaths in patients with multiple injuries occur in those patients with brain and spinal cord damage. Neurosurgical problems fit into the major categories of craniocerebral, spinal and peripheral nerve injuries. The last named requires no immediate treatment in most instances, but the first two may require early study and prompt action.

Head injuries require, as soon as possible, the arrest of surface bleeding, covering wounds with material for prevention of further contamination, and the maintenance of an adequate airway. Unless there is profuse bleeding from the scalp, head injury is not likely the source of shock. Simple compression of even arterial bleeding on the skull may be completely adequate. Head injury patients should be transported carefully, with the collar loosened and the patient face down or on the side to promote an adequate airway. Head wounds often may be adequately handled by simple shaving, washing, arrest of bleeding, application of dressing, and the administration of an antibiotic.

Until the patient is stabilized, x-rays should be obtained with caution for fear of furthering the already established damage or of producing new wounds. If x-rays are necessary in other portions of the body and the patient's condition permits, then both skull films and cervical spine films should be obtained.

The usually recognized neurologic signs of paralyses, spasticity and reflex aberrations may indicate increasing pressure or bleeding and may indicate early surgery. A most important localizing sign is the unilateral dilated fixed pupil. Other important signs include increasing temperature, slowing pulse, increasing blood pressure, and stertorous respiration. Leakage of cerebrospinal fluid from the nose or ear is a serious problem but usually requires no immediate treatment except antibiotics and routine care.

X-ray studies are helpful, especially if there is demonstrable a depression or a fracture across the mid-meningeal artery or displacement of a calcified pineal. Occasionally surgery must be undertaken on the basis of deepening coma even when it has been impossible to obtain adequate x-ray studies. Upon such occasions, decompression and hemostasis may be life saving.

It is of greatest importance that adequate supervision of the movement of the patient for examination be provided. Transportation with the support of normal curvatures of the spine and avoidance of extreme positions is essential. Intercostal paralysis with respiratory depression must be watched for. Tracheostomy in a patient whose respiratory reserves are already low may add to the effective respiratory volume. Intranasal or intra-tracheostomy oxygen may be advantageous.

Initial care of the cervical spine injury includes skeletal tong traction under local anesthesia, with prompt application of weighted traction.

The Critical Stage

During the critical stage of the patient's early post-accident condition, if possible, avoid surgery and anesthesia. Surgery may be necessary, however, for open wounds and for irreduceable dislocations and for persistent cord compression. If possible, surgery should be deferred until respiratory and circulatory states are improved.

Of particular importance is the extradural clot. It may not exhibit the classical sign of the extradural clot or subdural hemorrhage with a lucid interval followed by progressive coma. When the subdural clot can be evacuated and its source rapidly blocked, the attempt should be made even though more diffuse subdural hemorrhage is responsible. Active treatment of depressed fractures and other wounds of the head may be deferred for the short period need-

ed for more pressing injury care.

Frequently the matter of sedation of the patient and of anesthesia is brought up, particularly with regard to the brain damage. It is recognized, of course, that local anesthesia would probably be best in any instance. Morphine, pentothal alone, and spinal anesthetics are probably best avoided. For restlessness, sedation with chlorpromazine or paraldehyde along with the judicious use of small amounts of Demerol® may be permitted. It is usually recommended that necessary anesthetics may be given with ether, nitrous oxide and oxygen.

Fluid requirements of the unconscious or stuporous head injury patients should not be neglected. Dehydration programs for reduction of intracranial pressure are usually unwise, producing more problems than they effectively solve.

Spinal puncture, carefully done, adds information especially with regard to blood content and pressure of spinal fluid.

Injury to the spine and spinal cord must be considered and treated together. Debridement and laminectomy will be necessary for some open wounds, but associated severe chest or abdominal injuries will take precedence. Closed injuries of the cord with compression fracture or dislocation of the spine require initial meticulous handling and careful transportation to minimize or prevent further damage. Injury may vary from simple concussion of the cord to complete anatomic severance. Rapid neurologic survey may show the level of damage. Satisfactory treatment depends upon x-ray pictures, but these should be deferred until problems of shock and asphyxia are settled. Definitive treatments should be instituted as early as feasible and immobilization should be adequately prolonged.

Conclusions

This paper has been presented in the interest of recalling the principles of care of those whose wounds involve several systems. To be forearmed with a specific and systematic plan of evaluating the patient, with a definite appreciation of the most important phases of a patient's injury will help provide the quality of care which the patient deserves. Every physician should be capable of evaluating the patient's primary needs. Over-enthusiastic treatment of many injuries or time-consuming normal treatment of relatively minor wounds can be detrimental to the patient's total progress. An indecisive and casual approach to problems of asphyxia, hemorrhage and shock may be fatal for the patient. The relative priority of the various needs of each patient must be determined. It is our obligation to prepare our accident rooms, attendants, and especially ourselves to act promptly and effectively in the management of patients with multiple injuries. The equipment and personnel involved might be needed to handle one of your own family next.

Don't Forget

KSMA's Immunization Week

May 1 - 7

Bilateral Tubal Pregnancy

Erwin Asriel, M.D.*

Paris, Ky.

Report of a case associated with bilateral corpus luteum cysts and habitual abortion is presented. This is a very rare type of pregnancy

TUBAL pregnancy is generally believed to be due to arrest of the ovum during its migration from the fimbriated end of the Fallopian tube to its site of nidation in the endometrium. Such arrest is usually presumed to be caused by stenosis or obliteration of the tubal pathway. No doubt this is the case in many or perhaps in most instances. An illustrative case presented itself once in the author's own practice, when an ectopic pregnancy was observed in a previously ligated tube. This tube had obviously become recanalized with a lumen wide enough to allow passage of the spermatozoa but not of the ovum.

Bilateral tubal pregnancy is very rare. Burt et al.[1] and also Ross et al.[2] state that up to 1953 only 94 cases had been reported. Bilateral extrauterine pregnancy is less rare. Jarvinen et al.[3] stated that over 200 isolated cases had been reported. Abrams & Kantor[4] found the incidence to be one in 1,580 ectopic gestations. According to Stewart[5] this incidence is 1:725. Simultaneous intra-and extrauterine pregnancies occur more frequently. According to Kilkenny et al.[6], and to Reeves et al.[7] their occurrence is 1:30,000, or 0.003% of all pregnancies. The patient described here presents a bilateral tubal pregnancy with both tubes provenly intact and in which the condition of both ovaries allows the conclusion that factors other than mechanical were responsible for the nidation of both ova in the Fallopian tubes. Endocrine factors have repeatedly been suggested as being influential in the migration and nidation of the ovum.

Case Report

Mrs. E. A., a 29-year-old white female, was seen at her home on July 29, 1958, acutely ill, stating that for about one hour she had been suffering with severe peri-umbilical cramping, nausea, vomiting and bilateral low abdominal pain. Two days previously she had been given elsewhere a mild hypodermic sedative for some low abdominal pains of short duration. Since then she had been uncomfortable with low abdominal pressure feeling and urge to defecate, but no bowel movements despite several enemata. Her last menstrual period had been early June, and she had had none the following month. During the past 10 days she had noticed an unusual vaginal discharge which was at times dark brown, and at other times "spotting" red.

Her past history was significant. She had been married for more than 10 years and had been unable to conceive during the first five years. She had a spontaneous complete abortion in April, 1953. She was delivered of a premature baby weighing 4 pounds after a seven-month pregnancy in June, 1955. She had another spontaneous abortion at the end of the first trimester, in July, 1957. Catamenia were normal.

Examination revealed a slender young female in acute distress, with pale, grayish complexion, pale mucosa of lips and pale conjunctivae. Her temperature was 98°. Her blood pressure (reclining) was 128/60. Her pulse was rapid (128) but of good volume and regular. Both lung fields were clear and her respiration rate was 28. Physical examination of the precor-

*Attending physician and surgeon, Bourbon County Hospital, Paris, Ky.

dial region revealed no abnormality except the above mentioned tachycardia.

The patient's abdomen was somewhat distended, but soft. No abnormal masses could be palpated. There was intense bilateral lower abdominal tenderness, even on gentle pressure, and some "defense musculaire" was noted over the lower portions of both recti. Bilateral flank dullness was present.

There seemed to be no doubt that an intra-abdominal hemorrhage had occurred, most likely due to ruptured ectopic pregnancy. The patient was immediately hospitalized. Upon arrival at the hospital a sterile pelvic examination was performed. A large, patent, soft cervix was visualized, without any unusual endocervical secretion being present at that time. The corpus uteri was boggy and slightly enlarged. Both cervix and fundus were extremely painful on motion and palpation. A doughy mass was felt in the cul-de-sac. Both adnexal regions were extremely painful on palpation, the tenderness being too severe to palpate the adnexa with any degree of accuracy. The findings on rectal examination were about the same.

Hemogram revealed a hemoglobin of 9.5 grams with a red cell count of 3,210,000 and a white cell count of 25,850 per mm^3 with 83% neutrophiles, 1% eosinophiles, 2% stabforms and 14% lymphocytes.

Operative Findings

After starting an intravenous infusion of citrated blood, the patient was taken to the operating room and a laparotomy performed under general anesthesia. The abdomen was opened through a low midline incision. Upon entering the peritoneal cavity a large amount of dark, partly fluid, partly coagulated blood was encountered and removed by suction. The pelvic organs were then visualized.

The left tube measured about 10 cm. in length and showed a club-shaped swelling in the distal third, with a freely bleeding rent, onto which a large blood clot was loosely attached. The left ovary was completely transformed into a thin-walled whitish ovoid cyst measuring 5 cm. in its largest diameter. No grossly normal ovarian tissue could be seen. The right oviduct was also club-shaped and the swollen fimbriated end seemed to be plugged with a friable mass of spongy hemorrhagic tissue, which separated easily, again leaving a freely bleeding rent in the tube. In place of the right ovary was a spherical cyst similar to the other, measuring about 3 cm. in diameter. Again, no normal ovarian tissue could be seen. The uterus was slightly enlarged and appeared hyperemic and dusky red, but otherwise normal in every respect.

A bilateral salpingo-oophorectomy was performed and the patient recovered uneventfully.

Pathology Report

"Sections of the right Fallopian tube taken near the fimbriated end do not show perforation. The wall shows decidual changes. There is some acute inflammation consisting of edema and a sparse infiltration of leukocytes. There is some hemorrhage. The lumen contains chorionic villi. Fetal tissue is not identified. Sections of this tube do not show any evidence of chronic inflammation.

"Sections of the left tube show decidual changes within the wall. The wall is perforated. The lumen contains chorionic villi. There is no evidence of chronic inflammation.

" Fetal tissue was not found on gross examination or within the samples selected for section. Sections of the corpora lutea show the lutein layers of each essentially equal in thickness. Retrogressive changes are not evident. Microscopically, these are typical of corpora lutea of early pregnancy.

"Pathological Diagnosis:

"Ectopic pregnancy of right Fallopian tube with incomplete abortion from fimbriated end.

"Ectopian pregnancy of left Fallopian tube with rupture and incomplete abortion through rupture.

"Bilateral corpora lutea of pregnancy, and bilateral total cystic conversion of ovary.

"No evidence of chronic salpingitis.

Signed: H. Davis Chipps, M.D.
Pathologist."

Follow Up:

The patient was discharged from the hospital on the sixth post-operative day and has been re-examined periodically at the office. She has been completely amenorrheic, but has had no signs or symptoms suggestive of castration or artifically induced menopause. There have been

no more pelvic pains, and she states she is now feeling better than for many years. There have been a few "hot flushes" but not enough discomfort to require any medication.

Summary and Discussion

A case of bilateral tubal pregnancy (coeval) is presented, with both tubes being grossly and histologically patent and not otherwise diseased, and with both ovaries having undergone total cystic conversion. Previous to this event, the patient had been unable to carry any pregnancy to term. It is likely that the function of her ovaries had been subnormal before surgery. This may throw additional light on the cause of ectopic pregnancy and perhaps on the normal physiology of migration and nidation of the ovum.

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Bowen's Disease and Its Relationship to Systemic Cancer

The characteristic finding in the disease described by Bowen is a chronic solitary lesion composed of lenticular papules. The histological picture of atypical epithelial proliferation also occurs in multiple, nonelevated, scaly or crusted plaques. Specimens for study were obtained from 35 patients after death and were compared with similar materials from 35 patients with senile keratosis, 35 with squamous-cell carcinoma of the skin, 139 with exfoliative dermatitis, and many other patients with other cutaneous diseases. The average age of onset for the 35 patients with Bowen's disease was 54 years; the duration of the lesion from onset to surgery ranged from 5 months to 30 years. The lesions ranged in diameter from 0.7 to 13 cm with a median of 1.9 cm. They usually appeared as erythematous, pigmented, crusty, scaly fissured, keratotic plaques. Their configuration varied from round plaques, sharply demarcated from the surrounding tissue, to an irregular, polycyclic, lenticular pattern. They were firm, indurated, rough, and granular to palpation. The first lesion surgically removed was most frequently diagnosed as squamous-cell or basal-cell carcinoma, and only once was the diagnosis of Bowen's disease made at the first examination of a specimen. Surgical excision of the lesion is the recommended treatment; the need for sufficiently wide excision was indicated by the fact that in four patients the lesions were clearly invasive and in two others widespread metastases appeared. The evidence of an association of Bowen's disease with internal and cutaneous cancer was convincing, and it is suggested that the lesions are cutaneous manifestations of a systemic carcinogenic disease process.

James H. Graham, M.D., and Elson B. Helwig, M.D.
AMA Arch. Dermat. August 1959

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

An Intracranial Aneurysm Treated By Plastic Coating

Joseph Keith, M.D.*

THIS 21-year-old white male suddenly experienced severe generalized headache several minutes after a bowel movement. He lost consciousness for about 10 minutes, and on awakening was described as stuporous and was noted to vomit several times. He had been in good health, and the past history and system review were not remarkable.

Upon arrival at the hospital one hour later, examination revealed a thin, acutely ill man who was very lethargic. General physical examination showed a stiff neck, but no other abnormalities were noted. Neurological examination was essentially negative; the cranial nerves were intact, the motor and sensory systems normal, and deep tendon and other reflexes all normal. The pupils were equal and reacted briskly to light, and there was no evidence of superficial hemorrhage, exudate or papilledema. The initial impression was a spontaneous subarachnoid hemorrhage secondary to a ruptured intracranial aneurysm. A lumbar puncture showed an opening pressure of 380 mm., and the fluid was grossly bloody.

The patient was kept at strict bed rest and heavily sedated for three days with a grain of phenobarbital every six hours. On the fourth day, under general anesthesia, bilateral carotid and vertebral arteriograms were done. An aneurysm was visualized on the left middle cerebral artery just before the Trifurcation, and it arose from a broad base with no neck. Oblique films were taken to demonstrate its mode of origin from the middle cerebral artery, and all of these views verified the broad based origin of this aneurysm. No other aneurysm was visualized with the complete arteriographic study of both the anterior and posterior cerebral circulation.

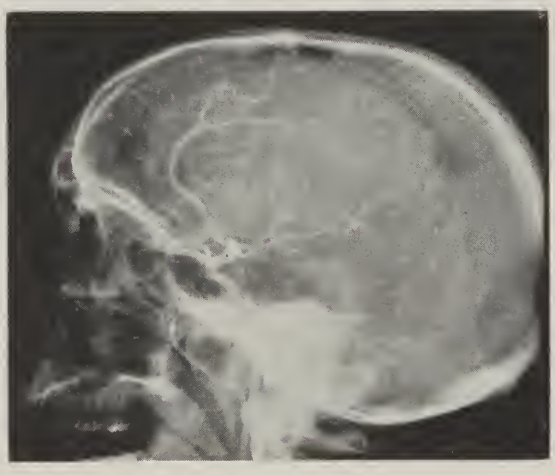


Figure 1

Preoperative Arteriogram

Two weeks after the episode of spontaneous subarachnoid hemorrhage, the patient was operated upon.

The patient was given a general anesthetic and placed in refrigerator blankets two hours prior to the actual surgery. The body temperature was lowered to 87° and maintained at this level until the operation was completed. A left parieto-temporal osteoplastic flap was turned down. The aneurysm was located in the

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Sylvian fissure and, after careful dissection, was isolated by placing cotton pledgets about it to give a dry field. Five layers of a liquid latex† were painted on the aneurysm, including about one centimeter of the artery both proximally and distally. Each layer was dried with a stream of nitrous oxide. A final layer of a polymerizing plastic was applied. The craniotomy wound was closed, and the temperature was allowed to return to normal.

The postoperative course was uneventful except for several focal convulsive seizures involving the right face and arm. These were controlled with anticonvulsants, and the patient was discharged from the hospital two weeks after surgery.

Ten weeks later he was rehospitalized, and the left carotid arteriogram was repeated. The aneurysm appeared unchanged with no evidence of enlargement. The middle cerebral artery distal to the aneurysm was well filled, and there was no evidence of any compromise of the circulation. Neurological examination at this time revealed no abnormalities.



Figure 2

Arteriogram 10 weeks postoperatively.

Discussion

The treatment of intracranial aneurysms, particularly those aneurysms arising from the middle cerebral artery without a neck suitable for clipping, remains a challenging, unsolved problem. It is a disease with a high mortality rate which increases with each episode of bleeding. The surgical treatment has been of relatively recent origin with most advances being made in the last 25 years.

Many approaches, both intracranially and extracranially, have been attempted. All of these techniques have some degree of success. Ligation of the carotid artery in the neck to decrease pressure in the aneurysm was one of the first extracranial approaches attempted and is used at the present time in certain cases. Direct approach with attempt to repair the aneurysm was an early intracranial procedure which proved to be a technical impossibility. Packing of the aneurysm in a bed of muscle to promote scar tissue formation has been of some success.

Silver clips can be applied to aneurysms with clearly defined necks, but this was not applicable in this patient because of the broad based origin. A clip placed at the base of this aneurysm would have narrowed the lumen of the artery producing ischemic changes distally. An aneurysm may be trapped between two clips placed proximally and distally on the parent artery, but this is possible only if there is adequate collateral circulation. This sacrifices the artery from a functional viewpoint, and in this case was contraindicated because the patient would have become aphasic and hemiplegic.

The method of treatment used in this case is undergoing clinical evaluation in several neurosurgical centers. The plastic has the advantage of being usable ragardless of the attachment to the parent artery. The plastic permits the artery to retain its resiliency and yet prevents dilatation of the aneurysm and rupture. The material is non-reactive in cerebral tissue. It may be used to coat multiple aneurysms.

Certain disadvantages exist which are mostly involved with the proper application of the plastic. Some aneurysms are located in such positions as to prevent adequate isolation and total surface coating. The dissection may rupture the aneurysm with disastrous results. Therefore, the arteries in the neck are isolated to permit compression in the event of rupture. With the patient in hypothermia it is possible to obliterate the arterial supply to the brain for several minutes without irreparable damage.

It is impossible to evaluate this plastic coating technique because of the relatively short followup. It certainly opens up a new avenue for the treatment of aneurysms, which may arise from the middle cerebral artery, and particularly those that have a broad base.

†*Supplied through the courtesy of Dr. Bertram Selverstone, Tufts University School of Medicine.*

SPECIAL ARTICLES

The Relative Value Studies

IT should be quite obvious that certain socio-economic changes are taking place. No matter how satisfied we are with our present status, there are others who do not share this complacency. Strong political groups are at work to change the free enterprise system which has made this nation what it is today. We cannot oppose this trend by simply ignoring its existence. We must fight it with all our might and at the same time prepare for any eventuality, no matter how distasteful it might be to us in the private practice of medicine.

Whether we like it or not, the ogre of the third party in medicine is here to stay. By this, I do not mean that the great catastrophy of socialized medicine is imminent, though this, too, is a remote possibility. I mean that the need for us to deal with third parties such as welfare agencies, insurance companies and unions is now a part of modern medicine.

Most of us retain the high hope that the people of this country have enough foresight to resist those of radical leanings who would wreck our system which has contributed to this country's outstanding medical care. Nevertheless, we can actively assist in this resistance and at the same time help the profession in other ways. The plan of Relative Values presently advocated is a sound, logical step in this direction, not only as a stopgap, but in addition is a useful instrument for our own good and convenience.

Actually, the present recommendations are for nothing more than a study of relative values. The results of this study need not be put into practice unless we wish to do so. It is a rather narrow viewpoint to oppose the study as something to be avoided for fear we might like the change and thereby adopt it. Strictly speaking, the basis of Relative Values is not a fee schedule of any type, though obviously we can convert the value schedule to a dollar value simply by the inclusion of a conversion factor. This factor would be one of our own choice and would be used in an entirely voluntary manner by any of us who desires for his own individual use.

This conversion factor should not be fixed, but allowed to fluctuate with changes in the index of living or even in the circumstances of the individual physician. In other words, alterations of the conversion factor can help us keep abreast with the general economic trend without in any way disrupting the relative value scale itself.

The relative value scale differs from the conversion factor, in that it is a fixed scale which must be established by the medical profession as a group. The study proposed is an opportunity for physicians themselves to determine a relative value for each of the various procedures they perform. This, then, is a relative value of any specific service as compared with the value of a basic service, for example, an office visit. It is a plan primarily established by physicians. It can be of great value to one in his own office in establishing his own fees without regard for anyone else. If desired, it can be used for negotiation or for fee consideration with any third party from the Government down.

If any of us object to the consideration of anything even remotely related to fee schedules, we should stop to consider the facts that these schedules are presently in use and have been since the establishment of Workmen's Compensation in the early part of this century. The antiquated schedules now in use are primarily of this origin, with only slight changes made by insurance companies and welfare agencies. They are at present imposed upon us without regard for our consideration. These

schedules are non-medically inspired and not realistic. Although we have not been satisfied with them, we have made little effort to change them.

We tend to blame third parties for these discrepancies, yet we ourselves are mostly to blame. The third party sets the schedule for one primary purpose. That party must have some idea of charges on which to base statistical studies for premium or budget purposes. This can be done in one of three ways: by hiring physicians, to which we object; by setting their own schedules, which we do not like; or, by obtaining information directly from physicians, which might not be too bad.

If we are even remotely concerned with the increasing development of third party medicine, I do not see how we can overlook this opportunity to produce a realistic value for services rendered. If we continue to shirk our duties in this, it may be done for us to our everlasting regret.

The scale proposed is one of relative values between various procedures, not a relative value of the services of various physicians. There is the same relative value for all. It is in no way a qualitative control. The qualitative controls which now apply would continue to exist.

In practice there has been found no need for dual fee schedules for rural and urban areas, or for general practitioners and specialists. There should be no attempt to establish a relative value of one group's work with that of another. Those groups which alone offer certain procedures should be allowed to establish the relative value of these procedures. Procedures common to various groups should be decided by the groups involved. Committees which finally determine the exact value scale should be representative of all groups.

Certain ground rules which have been established by trial and error might be mentioned as examples. In actual practice it was soon determined that fee schedules dealing with dollars are found to be entirely inaccurate, due to the variation in fees normally charged in different locations and by different groups.

It was quickly recognized that certain groups with very high overhead, such as radiologists, should be given special consideration for this expense. Others with office practice primarily and with somewhat less overhead were given consideration according to this factor. Those with relatively low overhead expense were appropriately and fairly treated from this standpoint.

There are occasions when there is definite need for varying conversion factors. This is particularly so in dealing with reduced fees for low income groups. It has been found that a blanket 20 per-cent off for certain individuals such as the over 65 years of age and limited income group could be grossly unfair to some physicians. On the other hand, by varying the conversion factor, all groups obtain full and adequate consideration.

These and various other rules have been worked out by those who have taken the initial step in such value studies and have been found to be most practical. We owe a debt of gratitude to them for the work they have done. The fact that the California study is considered as a basis for our own study is simply to avoid the intensive study, pioneer statistical work and enormous expense absorbed by physicians of that state. With this as a working basis, we can simply make the necessary changes found more appropriate for us in Kentucky. The results of the California study, determined through sweat and toil, are available to us simply for the asking.

Although the relative value study in Kentucky is long overdue and I hope will be adopted, there are certain drawbacks regarding it which should, in all fairness, be stressed.

It must be remembered that the study derived is for the benefit of physicians and their patients. It is not and should not be used as a publicity or a public relations instrument. Such use is the only way that it could lead to our disadvantage.

Although the majority of us are unalterably opposed to the service-type insurance plan, a schedule of this type would be of great benefit should we be coerced into adopting such a course. At least we would have a hand in the establishment of the fixed fees which would result. It would also be of great value to us and to the insurance carrier in the negotiation of an adequate indemnity plan, which would allow for the satisfactory approximation of fees. Any of us who were involved in the fee schedule negotiations for Medicare are well aware of the need for such a study.

W. C. Buschemeyer, M.D.

EDITORIALS

Urinary Calculi

THE earliest medical records found refer to stone in the urinary tract and describe with clarity the symptoms of pain and haematuria incident to the passage of gravel from the urinary bladder. Examination of some of the earliest mummies found not only show the presence of the calcified eggs of the parasite of Bilharzia but free calculi in the kidney and bladder as well. From these findings we may logically suppose that prehistoric man suffered from pain, haematuria and dysuria as does modern man, and we know that by the time of Hippocrates (second century before Christ), the occurrence of stone must have been rather common and its treatment occupied the thoughts of the medical fraternity to a large extent. According to the records, it turned the thoughts of not only the attending physician but the patient as well toward surgery as a means of relief, (the oath of Hippocrates) activated no doubt by the observation that spontaneous passage was followed by sudden and complete relief of symptoms. Excepting only circumcision, it is quite likely that incision and drainage of abscess secondary to stone represented man's first attempt at surgery. It was not until 1881, however, that Morris first successfully and intentionally removed a stone from the uninfected kidney.

Down through the centuries men, and probably animals as well, have continued to suffer from and to be baffled by the formation of urinary stone. It has been only relatively recently that attention has been focused on prevention rather than treatment. In this time there has always been the simple question why. The answer is still incomplete. We do know many things which contribute to, if not actually produce, stone not known only a short time ago. We have found over the years that certain diseases are accompanied by a relative increase in the instance of stone formation and that certain changes in metabolism influence stone formation, notably uric acid (gout) and cystine.

By far the greater number of stones are small and are symptomless until they become located in the ureter where, due to obstruction to the free flow of urine, they cause pain with or without haematuria and secondary bladder symptoms of frequency and dysuria. Being the larger group, these stones may be considered the most important and fortunately about eighty-five per cent of them will pass spontaneously or are more or less easily removed by manipulation through the cystoscope, either with the use of the stone basket or by simple dilatation alone. Needless to say, the less the manipulation the better since prevention of trauma to the ureteral lining is of the highest importance in the prevention of later fibrous reaction and stricture formation which in its turn may, through obstruction to free urinary outflow, lead to stasis, infection and further stone formation. This is especially true in the alkaline or triple phosphate stone.

There is no complete explanation for the formation of all stones. The relatively few in which we feel that we have the answer are those formed as the result of metabolic disturbances, that is, pure uric acid stones (gout), pure cystine stones and, with reservations, oxalate stones, but these crystals are also precipitated along with calcium, ammonium salt and phosphate, thus making the finding of a stone composed of only one substance a rarity indeed. Thus it becomes evident early that a chemical analysis of the removed stone is of the greatest importance in the future treatment of the pa-

tient, particularly so since the person who has formed one stone has a greater than a twenty per cent chance to form a second, and this chance is the same over a ten-year period.

One must recognize the fact that all the crystals necessary to the formation of stone are normally present in the urine and in the quantities of supersaturation, remaining in solution under normal condition through a balance of osmotic pressures. Mild imbalances lead to the precipitation of crystals in the urine (urates and Oxalates) but do not necessarily lead to stone formation—stones form usually only in the presence of one or more of the additional factors of obstruction, stasis either general or local, injury, infection, or the presence of a foreign body. In short, a nidus or matrix upon which the precipitated crystals may accumulate seems necessary.

The importance of primary disease states influencing stone formation should not be overlooked. Dr. Fred Garvey and co-workers emphasize the following conditions: Primary hyperparathyroidism, Burnett's disease (milk-alkali syndrome), Multiple myeloma, Renal tubular acidosis, Renal ricketts, acute osteoporosis (immobilization), Hypervitaminosis D, Sarcoidosis (Boeck's disease), Pagets disease (osteitis deformans), Bone metastasis and Metabolic imbalance of cystine and uric acid. As can be readily seen, the ruling in or out of any one of these conditions may be a major achievement and will tax the ingenuity of both urologist and internist. In the presence of over activity of the parathyroid gland, there is a marked increase in the calcium metabolism—blood calcium being greatly elevated, phosphorus being reduced, and the urinary content of calcium being increased markedly. The stones formed in these cases, then, are primarily calcium salts of phosphates, urates and oxalates and frequently ammonium. The urine is alkaline and the stones usually small but rapidly formed and most often pass from both kidneys. The diagnosis should be made as soon as possible even if it necessitates an exploratory operation of the neck and thyroid. If hyperplastic or adenomatous parathyroids are removed, the recurrence of stone is usually stopped abruptly and further damage to kidney tissue avoided.

Acute osteoporosis was formerly a very prevalent disease because of long periods of inactivity secondary to fracture of bones. In these cases, rapid stone formation was the rule as the result of transfer of calcium from the bones to the urine. This situation is readily corrected by reducing inactivity to the shortest period and by keeping electrolytic balance as nearly normal as possible. Burnett's disease is readily diagnosed on history alone and can be corrected rather easily by change of dietary habits. The remainder of the diseases in which stone formation is a prominent feature are relatively easy of diagnosis, providing only that they are given proper attention in the general picture.

In any case in which the cause of stone is not readily apparent, steps should always be taken to ascertain the presence or absence of any of these diseases. An analysis of the removed stone is always and should always be a good starting point. If it is a primary stone made up of uric acid, oxalate or cystine, prevention of further stone should be rather easy of accomplishment. This would consist of changes in the PH of the urine to such a point that the stone would not form readily, dietary changes as in the treatment of gout, and in reducing the urine to a low specific gravity by simple fluid intake.

There are, in addition to the above factors and conditions, two well known but not too often considered factors in stone formation. These are: Obstruction (congenital or acquired) and infection. Obstruction leads to stasis and concentration of urine behind it and thus increases by these conditions alone the chances of crystal formation. The chances of infection in this pool of slow flowing urine is also increased and with infection there is necessarily reaction of the lining membrane, minute sloughing and accumulation of cellular debris and the formation of a nidus or matrix on which the precipitated crystals may accumulate. Thus stones may be formed without any general disease or abnormal metabolism. This type of formation was described a number of years ago by Randall of Philadelphia who showed rather satisfactorially the formation of small stones of various content secondary to local disease of the papille. The situation in any case is always worsened by the presence of infection and by the type of infection. Since the colon group of organisms is prominent in urinary infection, their activity on the chemistry of urea is always a fact which must be considered. Especially is this true in bad bladder infections following prostatic obstruction or diverticuli. Here rapidly-growing alkaline stones produce an almost

insufferable situation from the standpoint of the patient.

To summarize, then, the part and activities of the physician in the treatment and prevention of urinary stone: (1) A chemical analysis of the stone should always be made. (2) Any suspected disease or imbalance of metabolism should be carefully considered. (3) The type of infection present should be ascertained by repeated cultures and its sensitivity to drugs be determined. (4) All congenital or acquired obstruction should be eliminated. (5) Crystallurea should be diminished by dilution of the urine as much as possible, and (6) Reaction of the urine should be such as to make the formation of the stone under treatment as difficult as possible.

J. Andrew Bowen, M.D.

Plan Now to Attend

The 1960 KSMA Annual Meeting

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Topnotch Speakers • Specialty Group Sessions • Scientific Exhibits

ORGANIZATION SECTION

Need For Proper Immunization To Be Stressed May 1-7

The Kentucky State Medical Association, in cooperation with the State Department of Health, will again observe Immunization Week in Kentucky, May 1-7. In announcing the date, Delmas M. Clardy, M. D., Hopkinsville, chairman of the KSMA Committee on Public Health, said this would be the seventh year for the KSMA to sponsor this drive.

A special appeal will be made to all county societies by Irvin Abell, M.D., Louisville, president of the KSMA, asking them to contact and work with civic organizations and local public-health departments and requesting that each physician be personally responsible for seeing that his patients and members of their families are properly immunized.

The drive will stress the need for proper immunization against polio, tetanus, typhoid, diphtheria, whooping cough and smallpox. Preliminary figures for 1959, released by the State Health Department, indicate 17 persons died of these diseases during the past year.

15 Physicians On Senior Day Program May 16

Fifteen Kentucky physicians are slated to appear on the program of Senior Day, May 16, planned for the senior medical students at the University of Louisville School of Medicine. Featured speaker will be Lester H. Means, Washington, D. C., government relations director of the General Electric Company.

Senior Day, designed to help the medical graduate make the transition from academic medicine to actual practice, is held annually by KSMA, in close cooperation with the Jefferson County Medical Society and the U. of L. School of Medicine. This is the sixth year for the event.

At the dinner, the Jefferson County Society members are individual hosts to individual members of the graduating class.

The program arranged for the May 16 meeting is announced by N. L. Bosworth, M.D., Lexington, chairman of the KSMA Senior Day Committee, as follows:

Morning Session

Rankin Amphitheatre, Louisville General Hospital

12:00 Address—Irvin Abell, Jr., M.D., Louisville, KSMA president

Afternoon Session

Crystal Ballroom, Brown Hotel

N. L. Bosworth, M.D., presiding

2:50 Call to Order—Doctor Bosworth

2:55 "Bridging the Gap"—Oscar Hayes, M.D., Louisville

3:15 Panel, "Where You Practice"—Carl Fortune, M.D., Lexington, moderator; Sam A. Overstreet, M.D., Louisville; James C. Cantrill, M.D., Georgetown, and Garnett J. Sweeney, M.D., Liberty

4:00 "The Mechanics Of Setting Up a Practice" Carl Cooper, M.D., Bedford

4:30 Coffee Break

4:40 Panel, "Human Equation In Medical Practice" —Wyatt Norvell, M.D., New Castle, moderator; Frank Moore, M.D., Bowling Green; Donald Dudderar, M.D., Newport, and David M. Cox, M.D., Louisville

5:15 "Economics Of Medicine"—Thomas Meredity, M.D., Harrodsburg

5:35 "What Blue Cross - Blue Shield Means to You"—Ed McConnel, Louisville

5:45 "This Above All"—Douglas Scott, M.D., Lexington

Evening Session

Roof Garden, Brown Hotel

George A. Pedigo, Jr., M.D., Louisville, president of the Jefferson County Medical Society, presiding

6:30 Social Hour

7:00 Dinner

Address—Lester H. Means, Washington, D. C.

Joint meeting of KSMA and the Jefferson County Medical Society.

Ashland Blue Shield Affiliates With Kentucky Plan

The Ashland Blue Shield Plan, composed of eight Kentucky counties along the West Virginia border, has affiliated with Kentucky Physicians Mutual, Kentucky's Blue Shield Plan. Announcement of the transfer, which became effective April 1, was made by J. Vernon Pace, M. D., Paducah, chairman of the board of directors of KPM.

The action followed a petition by the Ashland group, which was unanimously accepted by the executive committee of the Kentucky board. A committee of three physicians was appointed by Doctor Pace to assist D. Lane Tynes, executive director of Kentucky Physicians Mutual, in working out the necessary details. W. Vinson Pierce, M.D., Covington, was chairman of the committee which also included Bran-

ham B. Baughman, M.D., Frankfort, and J. Duffy Hancock, M.D., Louisville.

The transfer involves more than 12,000 certificate holders from Boyd, Carter, Floyd, Greenup, Johnson, Lawrence, Martin and Pike counties. The plan has the full approval of the office of the Insurance Commissioner of Kentucky.

It was also announced that hospitals in the eight counties, formerly affiliated with the Ashland-Huntington Blue Cross, have voted to transfer to the Kentucky Blue Cross Plan.

SUA Inducts Dr. Bosworth

N. Lewis Bosworth, M.D., Lexington, chairman of the KSMA Committee on Public Information and Service, was inducted as president of the Southeastern Urological Association at its annual meeting in Jacksonville, Fla., on March 17. Alfred D. Mason, Jr., M.D., Memphis, was named president-elect of the association.

12th, 15th Districts Meet May 5 At Cumberland Falls

Physicians from 18 counties are expected to participate in the joint meeting of the Twelfth and Fifteenth Councilor Districts at DuPont Lodge, Cumberland Falls, on Thursday, May 5. Featured speaker will be Irvin Abell, Jr., M.D., Louisville, president of KSMA.

Announcement of the program was made jointly by Thomas O. Meredith, M.D., Harrodsburg, and Keith P. Smith, M.D., Corbin, Councilors of the Twelfth and Fifteenth Districts, respectively. Doctor Smith will preside in the afternoon and Doctor Meredith will be in charge of the evening session.

The afternoon scientific program, starting at 3 o'clock, will feature four speakers. Harry S. Andrews, M.D., associate professor of pediatrics at the University of Louisville School of Medicine, will discuss "Hypersensitivity In Children"; L. Douglas Atherton, M.D., instructor in urology, "The Enigmatic Female Bladder and Urethra"; Harold W. Baker, M.D., assistant professor of obstetrics and gynecology, "Adnexal Diseases—Diagnosis and Management," and Richard H. Segnitz, M.D., Lexington, "Gastro-Intestinal Tract Perforation In Infancy—Diagnostic and Management Woes."

Sharing the spotlight with Doctor Abell on the evening program will be the fifth scientific speaker, John S. Llewellyn, M.D., instructor in medicine at the U. L. Medical School. His subject will be, "Early Diagnosis of Diabetes Mellitus." The program has been approved for three hours of Category I credit.

M.D.'s Address Civic Groups

Woodford B. Troutman, M.D., Louisville, secretary of KSMA, addressed the Lions Club of Louisville at a meeting at the Brown Hotel on March 8. His topic was "Problems of the Aging."

Recently, Hoyt D. Gardner, M.D., Louisville, spoke on the same general subject before the Jeffersontown Rotary Club.

Health Department Winding Up Move to Frankfort

The State Department of Health is getting settled in its new $2,750,000 home in Frankfort. Its move from Louisville got under way on March 21 and was expected to be completed the week of April 11, according to the timetable of William A. Kanzinger, director of the department's bureau of finance and administrative services, who is in charge of the move.

First to go was the bureau of statistics and vital records. Then followed the divisions of licensure, legal services, hospital services and narcotic control, in the office of the Commissioner of Health. Commissioner Russell E. Teague, M.D., remained in Louisville until April 1.

The week of March 28 saw the move of the bureau of local health services, with its divisions of sanitation, nursing, dental health and health education, and the bureau of finance and administrative services, made up of personnel, budget and property control.

Scheduled to move the week of April 4 were the bureau of medical services, embracing the divisions of chronic diseases, TB control and preventive medicine, and the bureau of maternal and child health, including the divisions of maternal and child health and of school health.

Last to leave will be the bureau of environmental health, under which are the divisions of sanitation engineers, plumbers, and foods and drugs.

The laboratory will remain in the Louisville building at 620 South Third Street until after July 1, and will be open for service to physicians, Mr. Kanzinger pointed out. A branch laboratory will be kept in Louisville even when delivery of necessary equipment permits moving the major operation to Frankfort, he said.

Also remaining in Louisville will be an office for accepting applications for duplicate birth certificates, Doctor Teague said. Original birth and death certificates, as in the past, will be filed with the Louisville-Jefferson County Health Department, then transferred to Frankfort.

Mental Health Stays In L'ville

Present plans call for the Kentucky Department of Mental Health to remain in Louisville, Commissioner Harold L. McPheeters, M.D., has announced. Space in the new health building in Frankfort is unavailable because other services are already overcrowding its facilities, he said.

Whether the mental health unit stays at 620 South Third Street or moves to the new State Building being erected in Louisville is undecided. Space in the building has been requested, Doctor McPheeters said.

Dr. Combs Heads School Boards

Cooley L. Combs, M.D., Hazard, long active in civic affairs, was made president of the Kentucky School Boards Association at its annual meeting in Louisville on March 16. Doctor Combs is chairman of the KSMA Committee to Study the Constitution and Bylaws.

KAGP Congress Of Delegates to Be Established In May

For the first time, the Kentucky Academy of General Practice is establishing a Congress of Delegates at its annual meeting set for May 11-13 at the Kentucky Hotel, Louisville, announces the president, Daryl P. Harvey, M.D., Glasgow.

Doctor Harvey will preside until a speaker is chosen at the first session of the Congress at 2 p.m. May 11. The reference committee will meet from 4 to 7 p.m. the same day. Also scheduled are two meetings of the board of directors—the first on May 10 before the annual meeting convenes and the second on May 13.

During the meeting, KAGP will install its president-elect, John G. Archer, M.D., Prestonsburg. Doctor Archer is a member of the Council of KSMA and secretary of the Floyd County Medical Society. He is active in civic affairs of his county.

A feature of the annual session is the presentation of the Annual Family Doctor of the Year Award to a member of the Academy.

An excellent scientific program has been put together for the meeting. Among the outstanding speakers scheduled to participate are Brock Brush, M.D., Detroit; Harold Gifford, M.D., Omaha; Edward H. Rynearson, M.D., Rochester, Minn.; C. Walton Lillehei, M.D., Minneapolis; Simon V. Ward, M.D., New Orleans; Samuel F. Ravenel, M.D., Greensboro, N. C.; Jonathan F. Meakins, M.D., Montreal, Canada; George J. Garceau, M.D., Indianapolis; Ernest H. Yount, M.D., Winston Salem, N. C., Matthew Marshall, Jr., M.D., Pittsburgh, and Edward A. Troncelliti, M.D., Bryn Mawr, Pa.

Dr. Townes, Dr. Keeney Lecturing In South America

Charles Dwight Townes, M.D., professor and chairman of the Section of Ophthalmology at the University of Louisville School of Medicine, and Arthur H. Keeney, M.D., assistant professor of ophthalmology, left March 23 on a lecture tour to medical-school faculties and practicing ophthalmologists in six South American countries.

Cities on their itinerary are Rio de Janeiro and Sao Paulo, Brazil; Montevideo, Uruguay; Buenos Aires, Argentina; Santiago, Chile; Lima, Peru, and Bogota, Colombia. Plans call for them to spend four days in each city.

The physicians are making the trip by air and are accompanied by their wives. They expect to spend a few days vacationing before returning home about April 26.

The tour was arranged in 1959 by Moacyr E. Alvaro, M.D., executive director of the Pan-American Association of Ophthalmology, who died last fall. Alvaro lectureships have been awarded for some 18 years with invitations extended each year to one or two outstanding physicians from the United States or Europe. Doctor Townes and Doctor Keeney are the first Kentuckians to be so honored.

Dr. Philip Davidson, president of the University of Louisville, has sent an engraved silver seal to each of the medical schools visited by the Louisville team.

The Pan-American Association of Ophthalmology is an organization with several thousand members. The death of Doctor Alvaro is not expected to affect its program of lectureships, the Louisville physicians said.

Ob-Gyn Society Will Convene May 12-14 In Lexington

Edith L. Potter, M.D., professor of obstetrics and gynecology at the University of Chicago School of Medicine and a member of the staff of Chicago's Lying-In Hospital, will be the featured speaker at the annual meeting of the Kentucky Obstetrical and Gynecological Society, May 12-14, at the Campbell House in Lexington.



Dr. Potter

Doctor Potter will give two scientific presentations and appear on a panel, "Problems of Fetal Salvage." She is a 1925 graduate of Minnesota Medical School, Minneapolis, and is certified by the American Board of Pathology.

A luncheon for past presidents is planned for Friday, May 13, with the society's 1949 president, A. J. Whitehouse, M.D., Lexington, as host. Robert Monroe, M.D., Louisville, is the present president.

Special entertainment is being arranged for wives of members. This will include a bus tour of Lexington and nearby horse farms and a style show and luncheon at Campbell House on Friday.

The program for the three-day meeting has been announced by Douglas M. Haynes, M.D., Louisville, secretary-treasurer, as follows:

Thursday, May 12

10:00 A. M.—Registration

11:00 A. M.—Executive Committee Meeting

2:00 P. M.—Scientific Session, **Transmission of Viral Infections From Mother to Fetus,** Edith L. Potter, M.D.

3:30 P. M.—General Business Meeting

Friday, May 13

10:00 A. M.—Winning Resident Paper

10:30 A. M.—Panel, **Problems of Fetal Salvage;** Moderator, Silas H. Starr, M.D., Louisville

2:00 P.M.—Scientific Session, **Malformations of the Genitourinary Tract Observed In The Fetus and Newborn,** Doctor Potter

3:30 P.M.—Scientific Session, W. H. Parker, M.D., Owensboro

6:00 P. M.—Cocktail Hour

7:30 P. M.—Banquet

Saturday, May 14

10:00 A. M.—Meeting of Kentucky Maternal Mortality Committee; Robert Monroe, M. D., Louisville, chairman.

Surgical Society Set For Meeting At French Lick May 14

Bentley P. Colcock, M.D., of the Lahey Clinic, Boston, will be the featured essayist at the annual meeting of the Kentucky Surgical Society to be held May 14 at the Sheraton Hotel in French Lick, Ind. Eleven scientific papers are scheduled for presentation on the program announced by C. M. Bernhard, M.D., Louisville, secretary-treasurer.



Dr. Colcock

The society's Council will meet in annual session on Friday night, May 13, with the chairman, Francis Massie, M.D., Lexington, presiding. Following the scientific program Saturday afternoon, an executive meeting will be held for the annual election of officers and transaction of business.

A feature of the program will be the banquet Saturday evening, with M. Tershay, M.D., Deputy of the Turkish Parliament, Istanbul, as the speaker. His address on "Comparison of Surgical Practice In Turkey and the U.S.A." will combine humor with information, it is reported.

Doctor Colcock, whose specialty is thyroid and abdominal surgery, is a native of Canada. He received his M.D. degree from the University of Pennsylvania in 1933. He has served as chief resident surgeon at Philadelphia General Hospital and on the surgical staff at Lahey Clinic and the New England Deaconess and Baptist Hospitals in Boston. A lieutenant colonel in the Medical Corps during World War II, he was chief of general surgery at the Army General Hospital and received the Bronze Star Medal for service in Africa and Italy.

Branham B. Baughman, M.D., Frankfort, is president of the 123-member surgical society. The group limits its membership to 125.

The complete scientific program of the meeting follows:

Morning Session—9 to 12

Five-Year Review Of Peptic Ulcer Surgery In a Rural Community—Charles C. Kissinger, M.D., Henderson

Hiatus Hernia—John Harter, M.D., Louisville

Pneumocholecystitis—McHenry S. Brewer, M.D., Louisville

Problems In the Surgery of the Gallbladder and Bile Ducts—Bentley P. Colcock, M.D., Lahey Clinic, Boston

Restorative Arterial Surgery In Individuals With Arteriosclerotic Gangrene Of the Lower Extremities — J. Herman Mahaffey, M.D., Louisville

High Velocity Injuries Of the Thoracic Aorta—Alexander Haller, M.D., Louisville (by invitation)

Relation Of Breast Cysts to Cancer — Francis Massie, M.D., Lexington

Afternoon Session—1:30 to 3:30

Primary Repair Of Injuries to the Soft Tissues Of the Face—Andrew M. Moore, M.D., Lexington

Current Status Of Regional Enteritis After Three Decades—Martin S. Kleckner, Jr., M.D., Paducah (by invitation)

Voiding—Its Muscular Requirements—Robert Lich, Jr., M.D., and (by invitation) Lonnie W. Howerton, M.D., Louisville

Referred Pain In the Inflammatory Female Urethra—M. Randolph Gilliam, M.D., Lexington

Maryland Professor Will Address Anesthesiologists June 18

Martin Helrich, M.D., of the University of Maryland, is announced by the Kentucky Society of Anesthesiologists as the featured speaker for its joint meeting with the Indiana Society of Anesthesiologists and the Kentucky and Indiana Chapters of the American College of Surgeons at French Lick, Ind., on June 18.

Warren H. Ash, M.D., Louisville, president of the Kentucky society, said the Baltimore professor will speak on "Medico-Legal Aspects."

Doctor Helrich, who is head of the department of anesthesiology at the University of Maryland, was graduated in 1946 from the University of Pennsylvania, where he later was assistant professor of anesthesiology. He had a research fellowship in anesthesiology at the New York University Bellevue Medical Center in 1949, and a post-doctorate fellowship, American Heart Institute, 1953-55. He served as a captain in the Medical Corps, U. S. Army, in 1947 and 1951-53.

The program for the French Lick meeting also calls for a scientific panel.

U. L. Medical School Makes Seven Appointments

Seven new appoitnments were announced by the dean's office at the University of Louisville School of Medicine, following a meeting of the board of trustees.

Asa Barnes, M.D., Louisville, area administrator for UMWA, was promoted to associate professor of community health.

The appointments were: Edwin H. West, M.D., as associate professor of medicine; Mrs. Jean Evans, M.S.S., lecturer in social sciences; Steven Garritt Jan Vandenberg, Ph.D., associate professor of child-development research; Helen M. Gray, M.D., associate in child health in addition to being assistant professor of psychology; Mary Louise Vetter, M.S., research associate in physical medicine and rehabilitation; Louis C. Lippert, M.D., fellow in radiation therapy, and John Lewis Creech, Jr., M.D., instructor in surgery.

Resignations accepted were: Richard Barquist, M.D., as instructor in medicine; Sam S. Clark, M.D., as assistant professor of anesthesiology, and John W. Miller, M.D., as instructor in orthopedic surgery.

Sixth District Will Convene April 12 In Franklin

The KSMA's Sixth Councilor District will meet Tuesday, April 12, at the Franklin Country Club, it is announced by John Pepper Glenn, M.D., Russellville, councilor of the district. The Simpson County Medical Society, headed by Carter Moore, M.D., Franklin, will be the host.

Charlie A. Wood, M.D., Auburn, will preside at the meeting which will get under way at 7 p.m. with a social hour and dinner, followed by a scientific session. Two papers are scheduled for presentation: "Pulmonary Embolization," by W. C. Morris, M.D., pathologist who recently located in Bowling Green, and "Oral and Facial Pathology" by Harry Shaver, D.D.S., oral surgeon of Bowling Green.

The district is composed of Butler, Logan, Warren, Simpson, Edmonson, Barren, Allen, Metcalfe, Monroe, Adair and Cumberland counties.

66 Accredited Hospitals Listed In Kentucky

Kentucky has a total of 66 accredited privately-operated hospitals, according to the seventh listing of the Joint Commission on Accreditation of Hospitals, Chicago. This compares to 56 in Indiana and 53 in Tennessee.

Also located in Kentucky are seven accredited hospitals operated by U. S. Government Agencies.

The omission of a hospital from the list does not necessarily mean that the institution fails to meet the standards of the commission, it was pointed out by Kenneth B. Babcock, M.D., director. Hospitals with less than 25 beds are not eligible for accreditation and only those hospitals which request a survey are visited.

The Kentucky list follows:

Ashland—District Four State Tuberculosis, King's Daughters and Our Lady of Bellefonte; Berea—Berea College; Bowling Green — Bowling Green-Warren County; Corbin—Southeastern Kentucky Baptist; Covington—St. Elizabeth and William Booth Memorial; Danville—Ephraim McDowell Memorial; Dayton—Speers Memorial; Elizabethtown—Hardin Memorial; Fort Thomas—St. Luke Hospital of Campbell County; Frankfort—King's Daughters; Glasgow—District Six State Tuberculosis and T. J. Samson Community.

Greenville—Muhlenberg Community; Harlan—Harlan Memorial; Hazard—Hazard Memorial and Mount Mary; Henderson—Methodist; Hopkinsville—Jennie Stuart Memorial; Jenkins—Sharon Heights; Lakeland—Central State; Lebanon—Mary Immaculate; Lexington—Central Baptist, Good Samaritan, St. Joseph and Shriners Hospital for Crippled Children; London—District Five State Tuberculosis and Marymount.

Louisville—Children's, District Two State Tuberculosis, Jewish, Kentucky Baptist, Kosair Crippled Children, Louisville General, Norton Memorial, Our Lady of Peace, Red Cross, St. Anthony, St. Joseph Infirmary and SS. Mary and Elizabeth.

Lynch—Notre Dame; Madisonville—District One State Tuberculosis and Hopkins County; Martin—Our Lady of the Way; Maysville—Hayswood; McDowell—McDowell Memorial; Middlesboro—Middlesboro Memorial; Owensboro—Our Lady of Mercy and Owensboro-Daviess County; Paducah—Riverside and Western Baptist; Paintsville—Paintsville Clinic and Paintsville Hosptial; Paris—Bourbon County and District Three State Tuberculosis.

Pikeville—Methodist Hospital of Kentucky and Pikeville Memorial; Pineville—Pineville Community Hospital Association; Russellville—Logan County; Scottsville—Allen County War Memorial; Shelbyville—King's Daughters; Waverly Hills—Waverly Hills Tuberculosis Sanitorium; Whitesburg — Whitesburg Memorial; Winchester—Clark County Hospital Association.

Government-operated hospitals in the state are: U. S. Army—Fort Campbell and Fort Knox; Public Health Service—Lexington; Department of Justice—Ashland; Veterans Administration—Dawson Springs, Lexington and Louisville.

Seventh District Meeting Set May 19 In Frankfort

The Seventh Councilor District will meet Thursday, May 19, at the Frankfort Country Club, according to announcement by Wyatt Norvell, M.D., New Castle, councilor of the district.

The KSMA president, Irvin Abell, Jr., M.D., Louisville, will speak and a scientific program, featuring four papers, will be presented. The afternoon session will start at 3 o'clock (Central Daylight Savings Time).

Host for the meeting will be the Franklin County Medical Society, headed by Joseph Liebman, M.D., Frankfort. Hugh C. Williams, M.D., Carrollton, president of the district, will preside.

Expected to participate are physicians from the district's 10 counties—Anderson, Carroll, Gallatin, Grant, Franklin, Henry, Oldham, Owen, Trimble and Shelby. The complete program will be announced later.

Second District to Meet May 31 In Owensboro

"Surgical Management of Recurring Pancreatitis" is announced as the subject of a scientific paper to be presented by Rudolf J. Noer, M.D., Louisville, at a meeting of KSMA's Second Councilor District at Gabe's Restaurant in Owensboro on May 31. Sharing the spotlight will be KSMA President Irvin Abell, Jr., M.D., Louisville.

The Daviess County Medical Society, headed by Jack Blackstone, M.D., Owensboro, will be the host group.

Announcement of the meeting was made by Walter L. O'Nan, M.D., Henderson, councilor of the district. KSMA members from the district's seven counties—Daviess, Hancock, McLean, Ohio, Union, Henderson and Webster—are expected to attend.

NEW FROM

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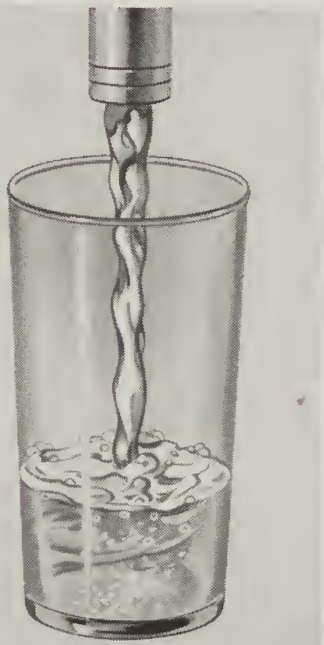
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Check This List For Postgraduate Opportunities In the Area

To keep pace with the expanding functions of the KSMA's Committee on Postgraduate Education, the Journal is devoting a special page each month to a listing of all postgraduate medical opportunities in Kentucky and adjoining states. Meetings are announced for a three-month period to give KSMA members an opportunity to plan ahead.

Detailed information on these listings may be obtained through the new Postgraduate Medical Office, 104 West Chestnut Street, Louisville 2. The telephone number is JUniper 7-7135.

PG offerings announced to date follow:

April

12 through May 31 — "University of Louisville Pediatric Postgraduate Course"; Children's Hospital, Louisville; 9:30 a.m. to 12:30 p.m. each Tuesday. Registration fee: $30, or $5 per day.

14 — Joint meeting of the 9th and 11th KSMA Councilor Districts, with five scientific paper presentations for general practitioners; T. B. Hospital, Paris; 3 p.m.

19 — State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

20 — Meeting of the 14th Councilor District, with three scientific-paper presentations for general practitioners; Hazard; 3 p.m.

20-21 — "Postgraduate Course in Diagnosis and Treatment of Heart Disease, Including Special Tests"; Indiana University School of Medicine, Indianapolis; fee, $20.

27-30 — "Postgraduate Course on Fractures and other Trauma", John B. Murphy Memorial Auditorium, Chicago; a faculty of outstanding teachers, sponsored by the Chicago Committee on Trauma of the American College of Surgeons under the direction of Sam W. Banks, M.D., 50 E. Erie Street, Chicago 11, Ill. For information, write to John J. Fahey, M.D., 1791 Howard Street, Chicago 26.

May

5 — Joint meeting of the 12th and 15th Councilor Districts, with five scientific-paper presentations for general practitioners; Du Pont Lodge, Cumberland Falls; 3 p.m.

9 — Kentucky Chapter of the American Academy of Pediatrics, annual meeting; University of Kentucky Medical Center, Lexington.

11-13 — Kentucky Academy of General Practice, annual meeting; Kentucky Hotel, Louisville.

12-14 — Kentucky Obstetrical and Gynecological Society, annual meeting; Campbell House, Lexington.

17 — State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

18-19 — "Postgraduate Course in Diagnosis and Treatment of Common Endocrine Disorders"; Indiana University School of Medicine, Indianapolis; fee, $20.

18-20 — "Postgraduate Course in Fractures and Dislocations"; University of Tennessee College of Medicine, Memphis.

25 — State Tuberculosis Hospital Chest Group meeting; State Tuberculosis Hospital, District 2, Louisville; 8 p.m.

25-26 — "Symposium on Selected Topics in Gastro-Neurology"; University of Kentucky Medical Center, Lexington.

25-27 — "Postgraduate Course in Psychiatry for the Family Physician"; University of Tennessee College of Medicine, Memphis.

June

9 — Joint meeting of the 4th and 6th Councilor Districts, with five scientific-paper presentations for general practitioners; Mammoth Cave Hotel; 3:30 p.m.

14 — State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

17-18 — Kentucky and Indiana Chapters of the American College of Surgeons and the Kentucky Society of Anesthesiologists and corresponding anesthesiology organization of Indiana joint meeting; French Lick, Ind.

20-24 — "Postgraduate Course in Internal Medicine," sponsored by the American College of Physicians; Indiana University School of Medicine, Indianapolis; Medical Science Building, Room B-26. Registration fee: ACP members, $60; non-members, $80.

July

19 — State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m; State Tuberculosis Hospital, District 2, Louisville.

27-29 — "Postgraduate Course in Tumors—Diagnosis and Treatment"; University of Tennessee College of Medicine, Memphis.

KSMA Lists New Members

Five new members have been enrolled by KSMA since the Journal's last report. They are: W. J. Hanley, M.D., Beaver Dam; Charles L. Kirkpatrick, M. D., Middlesboro; C. N. Tarkington, M.D., Lexington; C. A. Waldemayer, M.D., Butler, and Lewis Wash, M.D., Lawrenceburg.

Three U. of L. Instructors Get Heart Grants Of $37,820

Research grants totaling $37,820 to three faculty members at the University of Louisville School of Medicine have been announced by the American Heart Association.

Richard Duncan Dallam, M.D., associate professor of biochemistry, was named an AHA established investigator, to draw $15,220 - $9,500 salary and $5,720 for research work. He will study thyroid secretions.

Agamemnon Despopoulos, M.D., research assistant professor of pharmacology, received a second-year grant as an established investigator. He will get $16,100 - $10,600 salary and $5,500 to study how the kidney and liver move various drugs across the membranes of their cells.

Caspar Carrasquer, M.D., instructor in medicine and a fellow in physiology, was named an AHA advanced research fellow under William A. Brodsky, M.D. His third-year grant of $6,500 is for the study of the kidney as a "piece of machinery" that derives its power from chemical reactions.

Medical Research In Louisville Aided By Award, Will

Medical research in Louisville received two boosts last month—a $30,000 Markle Scholarship won by a professor of pathology at the University of Louisvile School of Medicine and a trust fund left to Jewish Hospital.

Hubert C. Pirkle, M.D., became the third member of the U. of L. medical faculty to receive a grant awarded by the John and Mary R. Markle Foundation of New York for research. A native of Indianapolis and a graduate of Indiana University, Doctor Pirkle joined the U. of L. staff in 1955.

Jewish Hospital is a beneficiary of the will of Sol Strauss, merchant of Paoli, Ind., who left part of his estate valued at $300,000 in trust for the institution. Income from about $76,000 was directed to be used by Jewish for heart research and to be known as the Sol Strauss Fund.

School For Retarded Children Names Medical Board

An 11-member medical advisory board has been formed by the Leroy R. Stevens School for Retarded Children in Louisville, it is announced by Mrs. Estelle Vincent, secretary of the Jefferson County Council for Retarded Children, which sponsors the school. Eleven physicians are among the consultants.

Martin Z. Kaplan, M.D., pediatrician, is chairman of the board. Other members are: Pediatrics, Mary O. Cruise, M.D.; Orthopedics, Rudy Ellis, M.D.; Otolaryngology, William C. Wolfe, M.D.; Ophthalmology, Roderick MacDonald, M.D.; Pedodontics, Harry Wilber, D.M.D.; Neurology, S. Taha Anvari, M.D.; Physical Medicine, Rex McMorris, M.D.; Psychiatry, Theodore Schramm, M.D.; Psychology, Sanford Klein, Ph.D., and Pathology, Ryland Byrd, M.D.

The school, a private institution located at 809 E. Washington Street, was founded in 1952 to train retarded children who are excluded from public schools. Now in its eighth year, it has an enrollment of 92 pupils ranging in age from 6 to 18. Its support comes from tuitions, donations and memberships.

The Council for Retarded Children carries on an educational program to enlist the public's interest in the Louisville school and also the Kentucky Training Home in Frankfort.

Heart Symposium Attracts 138 Physicians

A total of 138 physicians attended the Sixth Annual Symposium on Cardiovascular Diseases, held March 9-10 at the Brown Hotel in Louisville. Some of this number were present both days to bring the medical registration to 111 on March 9 and 95 on March 10.

Because of the deep snow in the area at the time, two of the scheduled speakers—Anthony P. Fletcher, M.D., St. Louis, and R. Bruce Logue, M.D., Atlanta —were unable to fill their engagements. Pierre Jean, M.D., Montreal, Canada, and Charles E. Wells, M.D., made the trip to Louisville a roundabout way, flying via Nashville.

For the first time in a number of years, exhibits of cardiac equipment were on display. The symposium was sponsored by the Heart Association of Louisville and Jefferson County, Inc., and the University of Louisville School of Medicine.

Mental Health Film Made In State

A movie depicting the rural community mental health program in eastern Kentucky has been made for the Department of Mental Health by the pharmaceutical firm of Smith Kline & French, the department's February Newsletter reports. The sequence was filmed in December on one of the monthly trips to that area by Ray Hayes, M.D., department psychiatrist, and his mental health team.

The finished film, which will be released for teaching purposes next summer, will include segments of special mental health programs in England and California.

Dr. Pierce Speaks In Atlanta

W. Vinson Pierce, M.D., Covington, KSMA delegate to the AMA and a member of AMA's Committee on Insurance and Pre-Payment Plans, spoke on old age coverage at a Regional Conference on Aging held in Atlanta March 7 and 8. Doctor Pierce addressed a similar conference in Cleveland last October.

Health Commissioner Renamed

Harold L. McPheeters, M.D., has been reappointed Commissioner of Mental Health by Governor Bert Combs. He has held that post since January, 1957.

Also renamed by the Governor was John H. Rompf, M.D., Lexington, to a four-year term on the Governor's Advisory Council on Mental Health.

NEWS ITEMS

Jesse L. Walker, M.D., Middlesboro physician, is headed for a new career as a medical missionary in Burma. Accepted over many applicants to become the understudy of Gordon Seagrave, M.D., he will leave June 1 to work in the famed surgeon's hospital three miles south of the Red China border. Accompanying him will be his wife who will supervise the School of Nursing, also operated by Doctor Seagrave. Treating tropical diseases is not new to Doctor Walker. During World War II, while serving with the 31st Infantry Division in the southwest Pacific, he operated a dispensary for 6,000 natives on the Island of Morati. Doctor Walker, a native of Georgia, is a graduate of the School of Medicine at Emory University, Atlanta.

Eli C. Boggs, M.D., was named Hazard's Outstanding Citizen of the Year at the city's eighth annual Civic Night banquet. Doctor Boggs, a City Commissioner, has been a leader in civic improvement for many years. He was one of the driving forces behind Hazard's municipal parking program.

Margaret Ann Livingood, M.D., is the new assistant medical director of the Frontier Nursing Service, Wendover. Specializing in pediatrics, she will practice at Wendover and Hyden. Doctor Livingood, a native of Berea, was graduated from Tufts University School of Medicine in 1951 and interned at University of California Service, San Francisco City and County Hospital. She held residencies in pediatrics at the University of California Medical Center Hospital, San Francisco, and Children's Medical Center, Boston, and a residency in internal medicine at Mary Hitchcock Memorial Hospital, Hanover, N. H. Doctor Livingood served as a captain in the Women's Reserve, U. S. Marine Corps, from 1943-1946.

Mark Dempsey, M.D., Garrett, was given a surprise party to mark his 85th birthday on February 1. Among those present to honor him was M. M. Collins, M.D., Lackey, who is 89. A native of West Virginia, Doctor Dempsey has practiced in Floyd and adjoining Knott and Magoffin counties for many years.

A fire in Shelbyville on February 10 destroyed the offices of **Donald Chatham, M.D.,** and **Robert Shipp, M.D.** The physicians estimated their loss in equipment at about $20,000. The fire destroyed a drug-store building in which the offices were located.

Walter C. Shea, Jr., M.D., has started practice in Princeton in association with N. H. Talley, Jr., M.D., specializing in internal medicine and obstetrics and gynecology. He formerly practiced in Mayfield. Doctor Shea, a native of Dyersburg, Tenn., received his M.D. degree from the University of Tennessee in 1956. He served a rotating internship in St. Thomas Hospital, where he was also a resident for two years. He served 18 months in the U. S. Army.

Keith N. Kirby, M.D., Burkesville, was cited as the Outstanding Young Businessman of the Year at the annual awards banquet of the Cumberland County Junior Chamber of Commerce on February 26.

B. H. Warren, M.D., is Owensboro's Boss of the Year. He received the title at the annual banquet of the Yellow Banks Chapter of the National Secretaries Association on February 18.

Surgeon General Cites Health Needs

A serious shortage of medical man power and the need to develop new patterns of health services were cited as two of today's major problems by Leroy Burney, M.D., surgeon general of the U. S. Public Health Service, in an address in Louisville on March 15. Doctor Burney spoke at a dinner marking the successful completion of the first phase of a 10-year campaign to raise $25,450,000 for the University of Louisville.

The surgeon general said that to maintain the present ratio of physicians to population—one doctor to about 1,100 persons—the number of physicians graduated each year must be increased from the present 7,400 to about 11,000 by 1975. This would require the equivalent of 20 to 24 new medical schools in operation by that time.

County Society Reports

McCracken County

Two applicants for membership in the McCracken County Medical Society were introduced at the February meeting: James O. Nall, M.D., Paducah's newly-appointed city physician who is transferring from Crittenden county, and Paul E. Davis, M.D., psychiatrist, recently employed at Western State Hospital, Hopkinsville.

Burton Haley, M.D., chairman of the legislative committee, reported on the progress of the Cancer Quackery bill in the State Legislature and pointed out the necessity of continued contact with Congressional legislators concerning the Forand bill.

An invitation to all members to attend the opening of the new Mental Health Center in Paducah on February 28 was extended by Rex Holland, M.D., of the mental health committee.

A motion by Chester M. Blanton, M.D., that the society consider taking wall space at one of the city's Junior League Ball Parks was referred to the public relations committee.

The secretary, Glenn R. Noss, M.D., was directed to send each doctor (active member) in the county a letter reminding him that he is responsible for giving polio vaccine inoculations to indigent children, and that if he is unable to give this service in his office he should contact some other member and make arrangements for it.

The latter action grew out of the address by the scientific speaker, Goodloe Sargent, M.D., Public Health Officer of McCracken county. His talk was on "Public Health Problems for the Private Physician."

In Memoriam

H. W. GINGLES, M.D.
Hazard
1889-1960

Hunter Watkins Gingles, M.D., died in Bowling Green on February 5 at the age of 70. Death was attributed to a heart attack.

Doctor Gingles, who formerly practiced in Hazard and Perry county, retired in 1954. He was a 1915 graduate of the Medical Department of the University of Louisville.

J. S. GOODPASTER, M.D.
Owingsville
1887-1960

Joseph Scott Goodpaster, M.D., retired Owingsville physician, died on February 21 in the Good Samaritan Hospital, Lexington. He was 73.

A native of Bath county, Doctor Goodpaster was a graduate of the University of Louisville and Johns Hopkins medical schools. Prior to World War I, he went overseas in a company of American doctors loaned to the English army. When this country entered the war, he was transferred to the U. S. Army with the rank of captain. After his war service, he practiced in Dayton, Ohio, and Lexington before returning to Owingsvile. He was health officer of Bath county for many years.

C. K. KERCHEVAL, M.D.
Ashland
1872 - 1960

Clarence Karl Kercheval, M.D., eye, ear, nose and throat specialist who retired in 1957 after practicing for 49 years, died on February 13 at his home in Ashland. He was 87.

A native of Lexington, Doctor Kercheval was graduated from the Medical Department of the University of Louisville in 1908. He practiced in Ashland for a time, then went to New York to take special training at the Lenox Hill and Manhattan Eye, Ear, Nose, and Throat Hospital.

J. L. Wilson, M.D.
Lexington
1918-1960

Joseph L. Wilson, M.D., staff psychiatrist at the Veterans Administration Hospital, Lexington, died suddenly at his home on February 26. He was 42 years old.

Doctor Wilson, a native of Mississippi, had been with the Lexington hospital for four and a half years. A graduate of Tulane Medical School, he was a former staff member of the VA hospitals in Omaha, Nebr., and Fort Lyons, Colo. He was a veteran of World War II.

C. F. McMillen, M.D.
Covington
1871-1960

C. F. McMillen, M.D., retired physician at Kenton County Infirmary, died on February 21 at St. Elizabeth Hospital, Covington. He was 89.

Doctor McMillen retired two years ago after a long practice in Kenton and Pendleton counties. He was an 1898 graduate of the Hospital College of Medicine.

PAUL E. MUNCY
Covington
1900-1960

Paul E. Muncy, M.D., Covington physician for more than 20 years, died on February 15 at Booth Hospital in that city. He was 60 years old.

Doctor Muncy taught English in high school for 11 years, from 1925 to 1934, before beginning the study of medicine at Eclectric Medical College. He received his M.D. degree in 1938.

The Eighth Congress of the Pan-Pacific Surgical Association is announced for September 27-October 5 in Honolulu, Hawaii. All members of the profession are invited to attend, and early registration is urged. The program will include 10 surgical specialty sections held simultaneously. Further information may be obtained by writing to Dr. F. J. Pinkerton, Director General, Suite 230, Alexander Young Building, Honolulu 13, Hawaii.

WASHINGTON NEWS DIGEST

(Continued from Page 434)

gist—this assures me that the patient will get top quality."

Doctor Robins appeared before the subcommittee as a private practicing physician and not in his capacity as a member of the AMA Board of Trustees.

Despite this testimony, Sen. Estes Kefauver (D., Tenn.), the chairman of the subcommittee, said he hoped physicians would give "serious thought" to use of generic terms. He contended that doctors thus could bring down drug prices by opening the way for small manufacturers to give the major companies "some good, honest, old-fashioned price competition."

Stronger X-Ray Laws Urged

President Eisenhower's Conference on Occupational Safety urged stronger x-ray legislation by the states with an aim of protecting consumers and workers against too much radiation.

The three-day conference also said there is need "for effective educational programs to reduce both consumer and occupational exposures to x-rays used for diagnosis and therapy, x-ray installations in industry for product control and related purposes and various x-ray devices, such as shoe-fitting fluoroscopes."

The conference also recommended intensive efforts to develop better ways of determining safe exposure levels of radiation.

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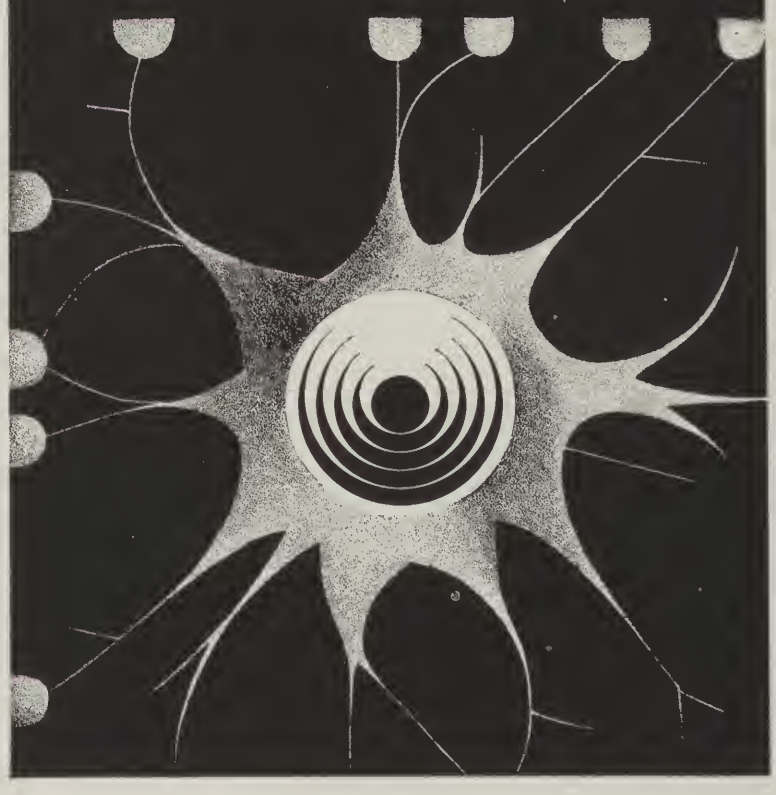
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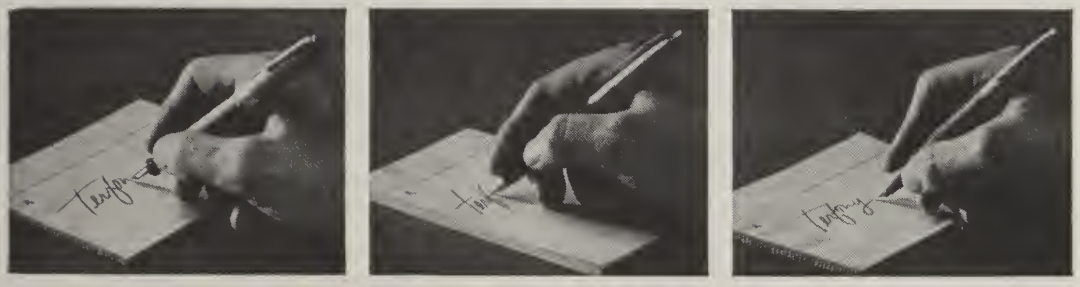
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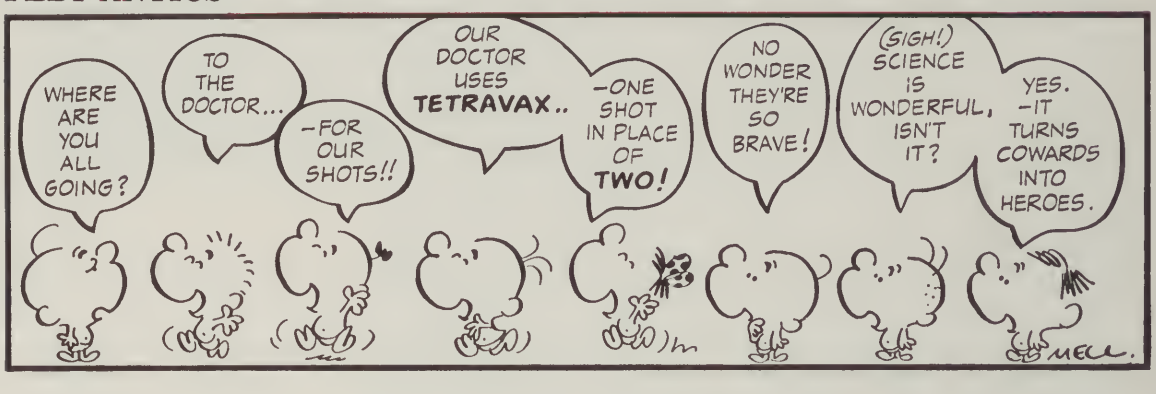
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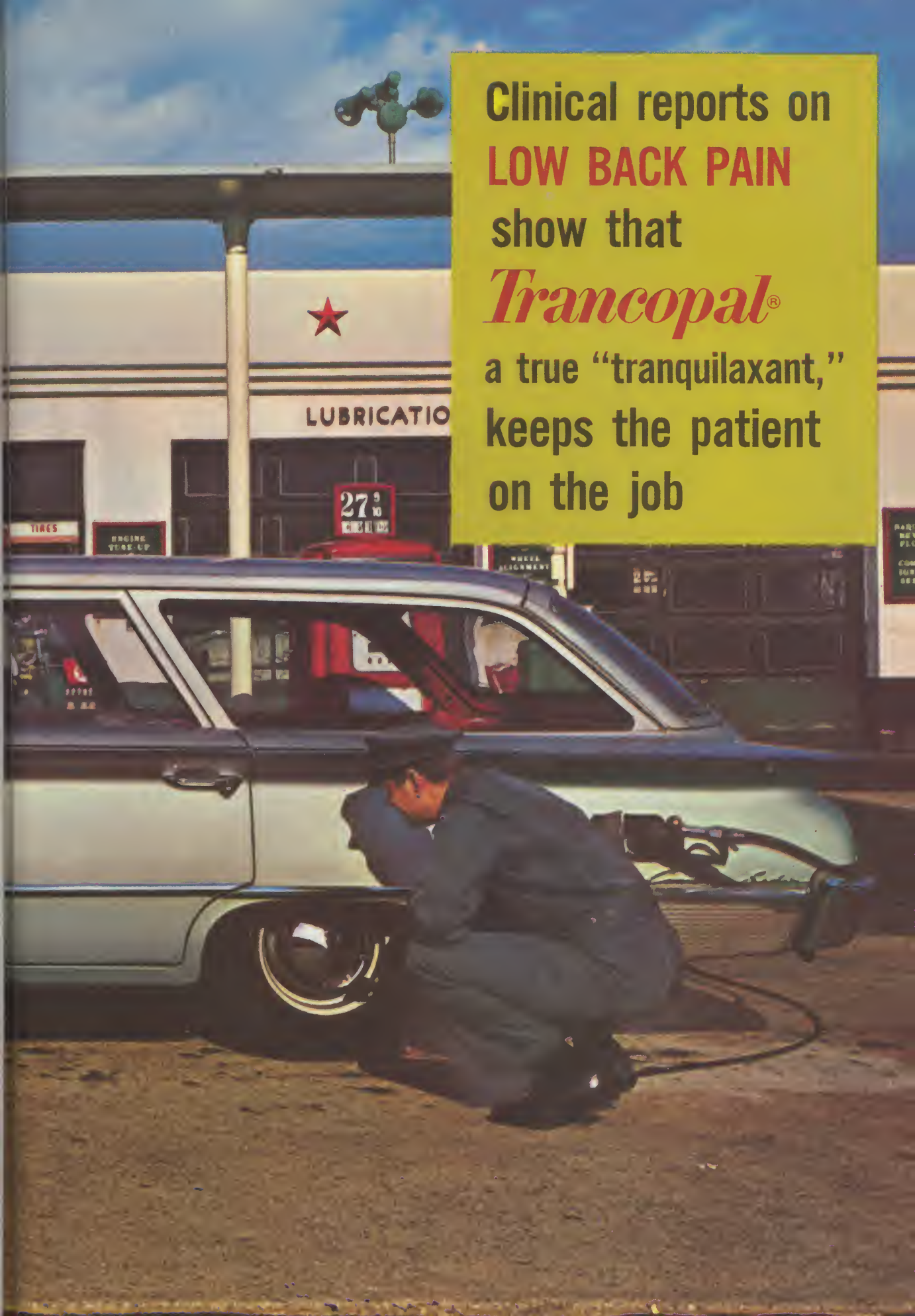
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relaxes skeletal muscle spasm so the patient can continue to work

Clinical experience shows that Trancopal will enable your patients with low back pain to keep going strong. Lichtman[1] reports that 310 of his 331 patients treated with Trancopal obtained satisfactory relief. These patients were suffering from low back pain, stiff neck, postoperative muscle spasm or other skeletal muscle spasms associated with trauma, bursitis, osteoarthritis and rheumatoid arthritis. Mullin and Epifano[2] reported that Trancopal brought relief to all of 39 patients with skeletal muscle spasm. In these patients, who had suffered from trauma, bursitis, rheumatoid arthritis, osteoarthritis, and intervertebral disc syndrome, the effect of Trancopal was ". . . excellent and prompt . . ."[2] Gruenberg[3] obtained marked relief with Trancopal in 258 of 304 patients with low back pain, torticollis, arthritis and other conditions associated with skeletal muscle spasm. Moderate relief was obtained in an additional group of 28 patients. Trancopal is a true "tranquilaxant" because "It combines the properties of tranquilization and skeletal muscle relaxation with no concomitant change in normal consciousness."[4] Side effects have been few and minor — and in no case were they serious enough to warrant discontinuing the use of Trancopal.[1] "Trancopal is exceptionally safe for clinical use."[3]

elieves anxiety and tension so the patient can carry on



Trancopal is also an effective agent for patients in anxiety and tension states. According to recent clinical reports,[1,5] it calms the patients but allows them to continue their work or other activity. Indeed, Lichtman found that his patients with anxiety ". . . were in many instances able to continue their normal activities where previously they had been considerably restricted . . ."[1] He observed that Trancopal brought good to excellent relief to 114 of 120 patients in anxiety states. Ganz,[5] who noted good to excellent relief in 32 of 35 patients with globus hystericus, and in his entire series of 100 patients in anxiety or tension states, comments: "Chlormethazanone [Trancopal], by relieving the psychogenic symptoms, allows the patient to use his energies in a more productive manner in overcoming his basic problems."[5]

Relieves dysmenorrhea — Trancopal has also proved to be a useful medication in the treatment of patients with dysmenorrhea,[1,4,6] probably producing its effect ". . . by means of a combination of muscle relaxant and tranquilizing actions."[4]

Indications

Musculoskeletal disorders		Psychogenic disorders
Low back pain (lumbago)	Ankle sprain, tennis elbow	Dysmenorrhea
Neck pain (torticollis)	Osteoarthritis	Premenstrual tension
Bursitis	Rheumatoid arthritis	Anxiety and tension states
Fibrositis	Disc syndrome	Asthma
Myositis	Postoperative muscle spasm	Angina pectoris
		Alcoholism

Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms generally occurs promptly and lasts from four to six hours.

How Supplied: Trancopal Caplets® 100 mg. (peach colored, scored) and 200 mg. (green colored, scored), bottles of 100.

eferences: 1. Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. 2. Mullin, W. G., and Epifano, Leonard: Am. Pract. & Digest Treat. 0:1743, Oct., 1959. 3. Gruenberg, Friedrich: Current Therap. Res. 2:1, Jan., 1960. 4. Shanaphy, J. F.: Current Therap. Res. 1:59, Oct., 1959. . Ganz, S. E.: J. Indiana M. A. 52:1134, July, 1959. 6. Stough, A. R.: J. Oklahoma M. A. 52:575, Sept., 1959.

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quiets the psyche but leaves the patient alert
"...TRANCOPAL is a most valuable drug for relieving tension, apprehension and various psychogenic states."5
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Lifts depression... as it calms anxiety!

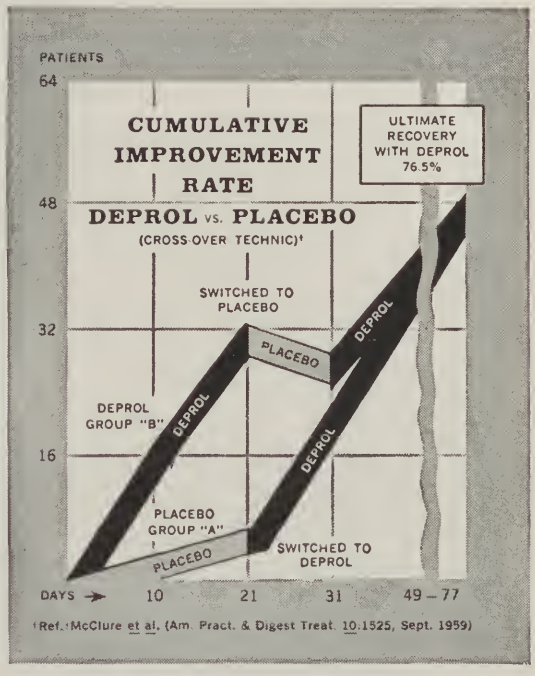
Smooth, balanced action lifts depression as it calms anxiety...rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.* And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within two or three days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within two or three days.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function – frequently reported with other antidepressant drugs.



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Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d. **Composition:** 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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PERTINENT PARAGRAPHS

A two-day institute on "Alcohol Intoxication and Influence" is scheduled for May 12 and 13 by the Western Reserve University Law-Medicine Center in Cleveland, Ohio. The program will emphasize the civil and criminal aspects of the topic, announced Oliver C. Schroeder, director of the Center. The enrollment fee is $25.

The Trudeau School of Tuberculosis and Other Pulmonary Diseases has set June 6 to 24 for its 45th session at Saranac Lake, N.Y. This annual postgraduate course, which provides training in the field of chest diseases, is conducted under the auspices of the Trudeau Foundation and supported by the Hyde Foundation. In addition to doctors from Saranac Lake, Ray Brook State Tuberculosis Hospital and Sunmount Veterans Administration Hospital, the medical faculty will include about 30 of the leading teachers and investigators in the Eastern United States and Canada. The tuition is $100.

"Changing Concepts Concerning Cancer" is announced as the theme of the Fourth National Cancer Conference set for September 13-15 in Minneapolis. Sponsors are the American Cancer Society and the National Cancer Institute.

The 14th annual Rocky Mountain Cancer Conference is set for July 20-21 in the new Denver Hilton Hotel in Denver. Tentative plans call for morning symposiums on "Skin Cancer" and "Thyroid Lumps," with the afternoon sessions devoted to papers on cancer detection and treatment by six outstanding physicians. Some 900 physicians from all parts of the country are expected to attend the two-day meeting, which is sponsored jointly by the Colorado division of the American Cancer Society and the Colorado State Medical Society. The course is worth 10 AAGP Category I credits.

The story of his recovery from a near-fatal heart attack in 1954 is told by a famous Kentuckian, Jesse Stuart, in an article in the February issue of Today's Health. The noted author and lecturer from Greenup advises his readers who are suffering from heart ailments "never to give up for they can live useful lives again if they can abide by the rules our skilled doctors ask them to follow." Now returned to normal life, Mr. Stuart is preparing to leave Kentucky in July for a year's teaching assignment at American University in Cairo, Egypt.

Total membership in the various Blue Shield Plans in North America reached 44,792,923 at the end of 1959, the National Association of Blue Shield Plans reported last month in Chicago. The net gain in membership for the year amounted to 2,217,667, as compared to an increase of 1,096,203 in 1958, the report stated. The new total represents an enrollment of 24 per cent of the total U.S. population and nearly 15 per cent of the Canadian population.

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Bottles of 4 and 16 fl. oz.

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IN THE BOOKS



TRAUMA: by Harrison L. McLaughlin, M.D.; published by W. B. Saunders Company, Philadelphia and London, 1959; 784 pages; price, $18.

This book is not as traumatic to the reader as its title would imply. Two questions immediately come to mind: first, is it written for the general practitioner and, second, is it aimed at covering topics presented from the standpoint of the specialist? The answer is no. However, it might be used to advantage as a reference text for both. The reason for saying this is contained in the introductory statement that Trauma "embraces the entire science of surgery."

In fact, much of the discussion of classification, complications and prognosis of conditions resulting from major traumatic causes is useless. It does not add to the armamentorium of the accomplished surgeon and is ridiculous for the inexperienced doctor to depend on. Were this presented as a discussion of first aid measures it would be more useful than the context of subjects which attempt to be omnipotent.

This compilation of monographs would be received more favorably, if they did not cover such a wide variety of conditions. And yet to the investigative and thoughtful individual who already comprehends much of ths book's content, the classifications and analytical discussions may be of some value. The illustrations, especially those dealing with the musculo-skeletal system, are very clear and self-explanatory. These alone make the book valuable for teaching purposes.

One might question whether 17 pages devoted to "injuries to the eye" is not either too much or too little discussion of this topic. As is true of the remainder of the text, however, this chapter has its value for reference purposes.

W. M. Ewing, M.D.

SYMPOSIUM ON GLAUCOMA: by William B. Clark, M.D.; published by C. V. Mosby Company, St. Louis, 1959; 314 pages; price, $13.50.

This book is a compilation of the papers given and panel discussions on the subject of glaucoma which took place in the 1957 session of the New Orleans Academy of Ophthalmology. The contributors to this book are outstanding researchists and teachers, as well as practicing ophthalmologists, whose material presented here covers the latest concepts of the disease and the most modern techniques of its recognition and management.

In the first 234 pages, the disease is divided into the various phases of histology, pathology, anatomy, biochemistry, diagnosis and treatment. The last 67 pages are devoted to a transcription of the round table discussions which followed each day's meeting, where the participants bring their experience and their theories more sharply into focus. The editor did a remarkably good job of keeping these questions and answers within a subject outline to avoid wasted space. This portion is most illuminating and probably will hold the reader's attention even more firmly than the first part of the book.

"Symposium on Glaucoma" was written with the intention of bringing the latest information on this widespread and frequently blinding disease, primarily to ophthalmologists. However, it is a well presented and rather complete short course in the subject, which offers an important message and is a ready reference for all teachers, students and doctors in other specialties who may have an interest in glaucoma.

Charles O. Bruce, M.D.

BABIES BY CHOICE OR BY CHANCE: by Alan F. Guttmacher, M.D., Obstetrician and Gynecologist in Chief, Mt. Sinai Hospital, New York: Clinical Professor of Obstetrics and Gynecology, Columbia Medical School; published by Doubleday & Company, Inc., Garden City, N. Y., 1959; 289 pages; price, $3.95.

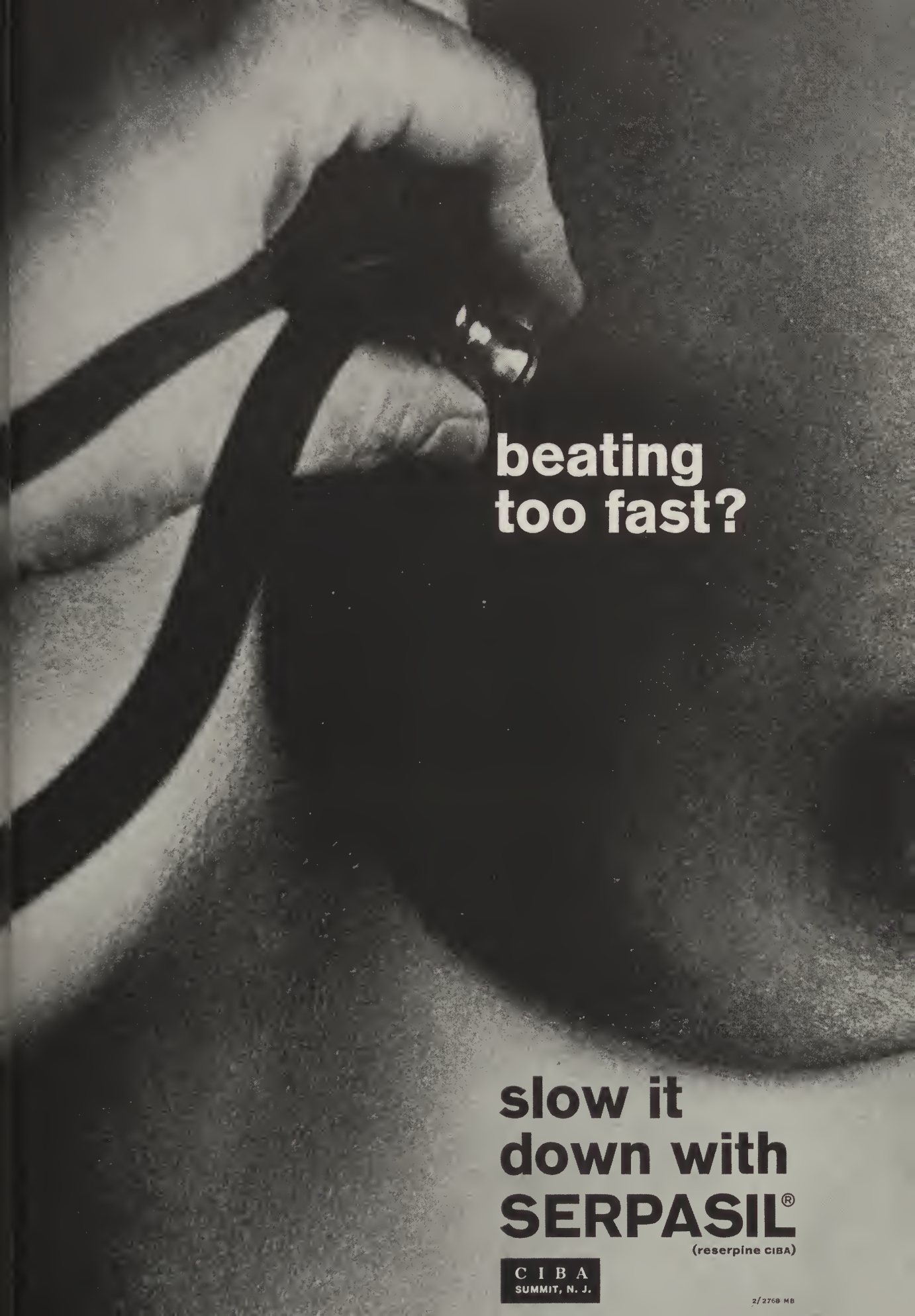
This book, primarily for non-medical public consumption, holds some interest for doctors. Parts and excerpts from it have already appeared in lay publications. The author devotes several pages to qualifying himself as an authority on the subjects covered in his book. Too often, in this reader's opinion, the author alludes to his own professional experience, training and standing in his chosen field, as though defying contradiction of his opinions.

The subject of contraception is thorougly covered. The medical, legal and religious aspects are discussed and interesting political ramifications are mentioned. Sterilization of both the male and female is given consideration. The procedures used and their indications are accurately described.

The abortion problem — spontaneous, therapeutic and criminal — is given short but adequate coverage. The unrealistic laws pertaining to abortion are cited. Several specific case reports are included to illustrate graphically how so-called legal therapeutic abortions are actually often illegal.

Infertility is covered for the reader and also a chapter is devoted to artificial insemination. The technical investigative procedures for the former and

(Continued on Page 511)


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*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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IN THE BOOKS

(Continued from Page 508)

the methods and legal aspects of the latter are clearly discussed and described.

All aspects of the subjects presented in this volume are well known to today's informed physician. Some historical, religious and legal discussions are perhaps less known and interesting.

The book is largely a presentation of the author's personal views on the control of conception and related subjects. His are liberal views with which many will agree and against which others will violently protest. Doctor Guttmacher boldly pleads for organized medicine to become more interested in those it serves than in its own economic security. He resents "that the church yields such stultifying powers in certain areas of medicine." If this book stimulates some physicians publicly to question medical, political and religious shackles it will have served its purpose.

Unfortunately, those who would best be served by "Babies by Choice Or by Chance" will likely not read it. This reviewer hopes the book will be made available in an inexpensive paper-back edition or be published as a series in a popular lay magazine.

Edwin P. Solomon, Jr., M.D.

Books Received

Following is a list of books received by the Association for review. Those considered of particular interest to Journal readers will be reviewed as space permits. All complimentary copies of books received are turned over to the University of Louisville-Jefferson County Medical Society Library. Inquiries concerning a particular book should be made to the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky.

CURRENT THERAPY—1960: edited by Howard F. Conn, M.D.; published by W. B. Saunders Company, Philadelphia and London.

THE OLDER PATIENT: by 21 authors—edited by Wingate M. Johnson, M.D.; published by Paul B. Hoebler, Inc., New York.

YOUR HEART—A HANDBOOK FOR LAYMEN: by H. M. Marvin, M.D.; published by Doubleday & Company, Inc., Garden City, N. Y.

HOPE DEFERRED: by Jeanette Seletz; published by Vantage Press, Inc., New York.

THE TEEN-AGE YEARS: by Arthur Roth, M.D.; published by Doubleday & Company, Inc., Garden City, N. Y.

A PRACTICAL GUIDE TO GENERAL SURGICAL MANAGEMENT: by Julian A. Sterling, M.D.; published by Vantage Press, Inc., New York.

MEDIEVAL AND RENAISSANCE MEDICINE: by Benjamin Lee Gordon, M.D., F.I.C.S.; published by Philosophical Library, Inc., New York.

DOCTOR STRAND: by Boris Sokoloff, M.D., Ph.D.; published by Vantage Press, Inc., New York.

THE STORY OF DISSECTION: by Jack Kevorkian, M.D.; published by Philosophical Library, Inc., New York.

MASTER YOUR TENSIONS AND ENJOY LIVING AGAIN: by George S. Stevenson, M.D., and Harry Milt; published by Prentice-Hall, Inc., Englewood Cliffs, N. J.

HERITABLE DISORDERS OF CONNECTIVE TISSUE: by Victor A. McKusick, M.D.; published by the C. V. Mosby Company, St. Louis.

THE RELUCTANT SURGEON: A BIOGRAPHY OF JOHN HUNTER: by John Kobler; published by Doubleday & Company, Inc., Garden City, N. Y.

SMOKING AND HEALTH: by Albert Ochsner, M.D.; published by Julian Messner, Inc., New York.

ENCYCLOPEDIA OF MEDICAL SYNDROMES: by Robert H. Durham, M.D.; published by Paul H. Hoeber, Inc., New York.

TEXTBOOK OF OTOLARYNGOLOGY: by David D. DeWeese, M.D., and William H. Saunders, M.D.; published by the C. V. Mosby Company, St. Louis.

DRUGS OF CHOICE—1960-61: Walter Modell, M.D., editor; published by the C. V. Mosby Company, St. Louis.

A DOCTOR ENJOYS SHERLOCK HOLMES: by Edward J. Van Liere, M.D.; published by Vantage Press, Inc., New York.

CLINICAL OBSTETRICS AND GYNECOLOGY: Cesarean Section edited by Edwin J. De Costa, M.D., Advances In Gynecologic Surgery edited by S. B. Gusberg, M.D.; published by Paul B. Hoeber, Inc., New York.

CHRISTOPHER'S TEXTBOOK OF SURGERY: edited by Loyal Davis, M.D.; published by W. B. Saunders Company, Philadelphia and London.

PRIMARY TUMORS OF THE CALVARIA: by Franklin Jelsma, M.D.; published by Charles C. Thomas, Publisher, Springfield, Ill.

All medical associations are invited to present recommendations for a postgraduate teaching film program planned by the German Medical Association, host for the XIVth General Assembly of the World Medical Association in West Berlin, September 15-22. A special "Film Recommendation Sheet" for the use of member associations is being issued by the WMA Headquarters Secretariat. Physicians are reminded that the General Assembly provides a good opportunity for them to use their Medical Diplomat passports.

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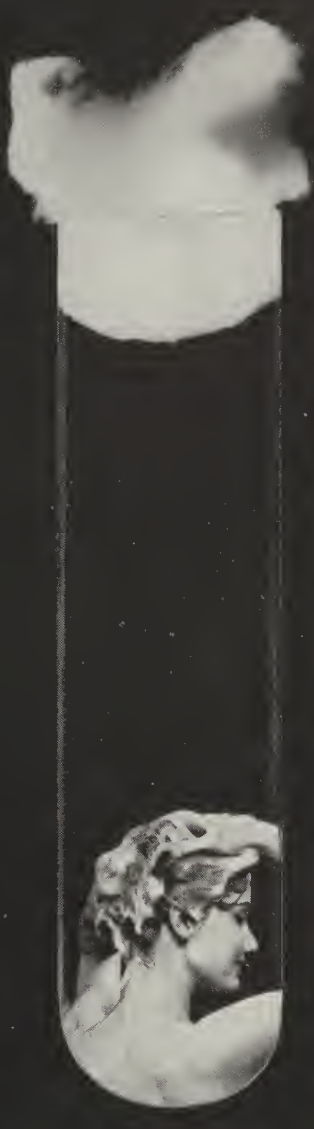
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- safe, nontoxic, nonirritating, nonsensitizing
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1. Spoor, H.: Proc. Scient. Sec. TGA No. 31, May 1959
2. Frank, L.: New York J. Med. 59:2892, 1959



helping the hypertensive to help himself...

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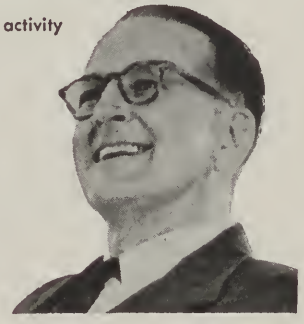
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DOSAGE: The usual dose of Theominal R.S. is 1 tablet two or three times daily. When improvement has been maintained for a time, the dose may be reduced or medication suspended occasionally until resumption is indicated.

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From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



Case #45: This patient was a 25-year-old married white gravida 5, para 4, whose last menstrual period was November 1, 1957. By menses she was due August 8, 1958. She consulted her physician in the fifth month of her pregnancy, and was seen five times.

Her past medical, surgical and obstetrical history was significant in that she had had difficulty with her last delivery. She had weakness in her left leg and was unable to walk for several weeks postpartum.

Her blood pressure rose initially in July to 150/90; she had no edema or albuminuria. She was treated with rest in bed at home.

Labor began spontaneously around 8 p.m., August 14, 1958. At approximately 10 p.m. the cervix was 6 cm. dilated and it was discovered that the presentation was a shoulder rather than vertex. The fetal heartbeat was not heard now, but had been normal about 30 minutes earlier.

An internal version was done, presumably with a breech extraction of an unweighed stillborn, at 12 p.m. Trilene with the Duke inhaler and Nisentil was the anesthetic. The mother was in good condition and was returned to her room awake. Approximately 20 minutes after delivery she began perspiring and complained of weakness and headache. No blood pressure was obtainable and her right pupil was dilated and fixed. Four cc. of Levophed in 5% G/W was given intravenously for the shock, but without response. Consultants were contacted prior to the patient's death but they had no suggestions to offer.

The patient became unconscious and expired at approximately 5 a.m. August 15, five hours postpartum. The cause of death on the certificate was cerebrovascular hemorrhage. There was no autopsy.

MONTH OF PREGNANCY

	1	2	3	4	5	6	7	8	9			
						July			1	2	3	4
Blood pressure				120/80		150/90	130/90	130/85	145/85			
Weight				140½		150½	150½	151	151			
Urine				neg.		neg.	neg.	neg.	neg.			

Rh+ VDRL non-reactive

Comment

The Committee felt this was a direct obstetric death, with the cause of death as listed on the certificate incorrect according to the information supplied. It was felt the cause of death was from shock, with possibly a ruptured uterus when the version was done, even though there was no mention of any external bleeding. The likelihood of a cerebrovascular accident in a 25-year-old producing the dilated pupil would be unusual, though compatible with the weakness and perspiring associated with shock.

The Committee felt internal version and breech extraction is a formidable procedure and should not have been attempted with nothing but Trilene for anesthesia, especially in a case where the fetal heart could not be heard, even though it was heard clearly thirty minutes before. In this case it would seem best to have allowed the mother to have continued to labor and attain more dilatation.

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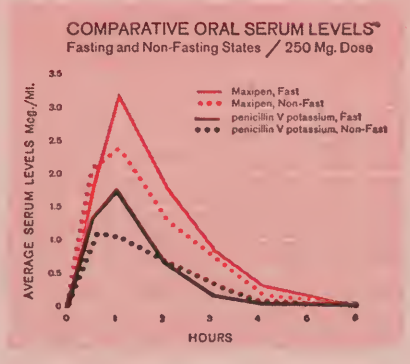
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Indicated in infections caused by streptococci, pneumococci, susceptible staphylococci, and gonococci



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DOSAGE: For moderately severe conditions, 125 to 250 mg. three times daily. For more severe conditions, 500 mg. as often as every four hours around the clock.

NOTE: To date, MAXIPEN has not shown less allergic reactions than older oral penicillins. Usual precautions regarding penicillin administration should be observed.

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PUBLIC HEALTH PAGE

An Outbreak Of Syphilis In Kentucky*

RUSSELL E. TEAGUE, M.D.

Commissioner of Health
Commonwealth of Kentucky

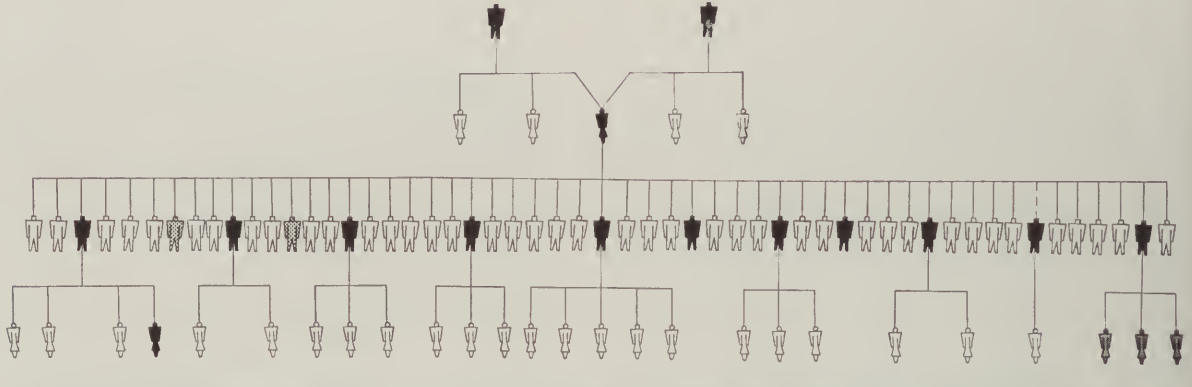
THE decline in the incidence of infectious syphilis has been remarkable during the past 17 years. This is due to two major factors: (1) the great sensitivity of T. pallidum to penicillin, allowing rapid treatment, and (2) the extensive case-finding program carried out by public health agencies. These factors have been so successful that today many young physicians complete their medical education without seeing a case of infectious syphilis.

However, since 1956 the nationwide incidence of syphilis has once again begun rising. In Kentucky alone, during 1959 there were 82 cases of infectious syphilis reported. This is opposed to 61 cases reported in 1958 and 47 cases in 1957.

This report is written to cite one outbreak of syphilis in a small community in Kentucky, and realert the Kentucky Medical profession that the "chancres" of primary syphilis are present and increasing in Kentucky.

In November, 1959, two Negro males were examined by their physician because of the presence of genital lesions. A diagnosis of primary syphilis was made in each case. The physician reported this information to the Health Department and gave his permission for the patients to be interviewed by a specially trained public health interviewer. Each boy named three contacts including the same 19-year-old female who was referred to her physician for examination. Her VDRL serological test was reactive and examination revealed "sores" on her body. These proved to be dark-field positive. She was diagnosed as having secondary syphilis and treated with a single

(Continued on Next Page)



The solid black figures in the above chart represent patients "infected with syphilis"; the white figures, those "not infected"; the dotted figures, "treated epidemiologically," and the diagonally-striped figures, "investigations pending."

**Paper prepared by William F. Hohn, M.D., U. S. Public Health Service, V. D. Clinician.*

injection of 2,400,000 units of Benzathine Penicillin G.

She was then interviewed for sex contacts. She named a total of 56 sex contacts during the past six months, involving Negro and white males. Physical examination for syphilis as well as quantitative VDRL tests were obtained on all these contacts. Of the total 56, 12 cases of early syphilis (10 primaries, one secondary, and one early latent) and one incidental previously-inadequately-treated case of congenital syphilis were found. These were all treated with a single injection of 2,400,000 units of Benzathine Penicillin G and instructed to receive a "blood test" in a specific number of months, and spinal fluid examination in one year. Those people found not infected were followed with serological examination for a period of four months after contact.

The known contacts of this one patient extended for a radius of 50 miles. The source of her primary infection can only be deduced from dates of contact and span of incubation period. Her definite source of infection is still not completely determined.

It is significant to note that this entire chain of infectious syphilis was brought under control as a direct result of the initial reports by the private physician to the health department and the subsequent epidemiological services which were performed.

For information concerning treatment, incidence, etc., of syphilis or other venereal diseases, write or phone the Veneral Disease Section, Kentucky State Department of Health.

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5-room, fully equipped office, completely air conditioned, full oil furnace, located at Burnside, Kentucky, on beautiful Lake Cumberland. Open staff general hospital 7 miles away in Somerset, Kentucky. Growing community with $25,000,-000 steam plant to be constructed beginning summer 1960. Population of Burnside 800, surrounding 10,000. Present doctor leaving for residency January 1, 1961. Sidney P. Edds, M.D., Burnside, Ky.

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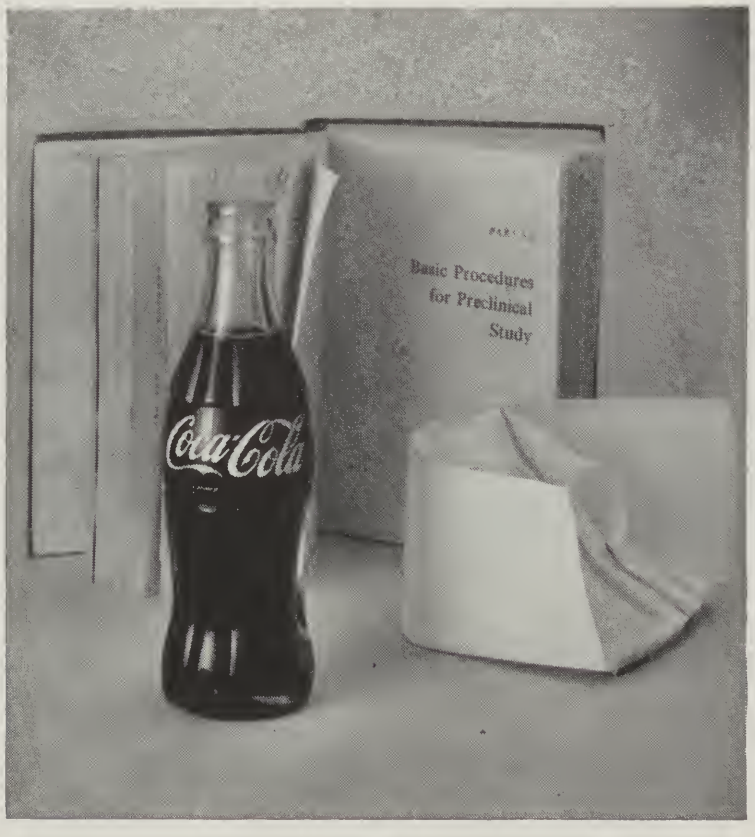
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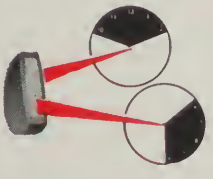
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Relief is prompt and prolonged because of this special timed-release action:



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Phenylpropanolamine HCl.....50 mg.
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Pyrilamine maleate.....25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides: ½ the formulation of the Triaminic Tablet.

Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides: ¼ the formulation of the Triaminic Tablet.

Dosage (to be administered every 3 or 4 hours): *Adults* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

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Committee on Scientific Exhibits

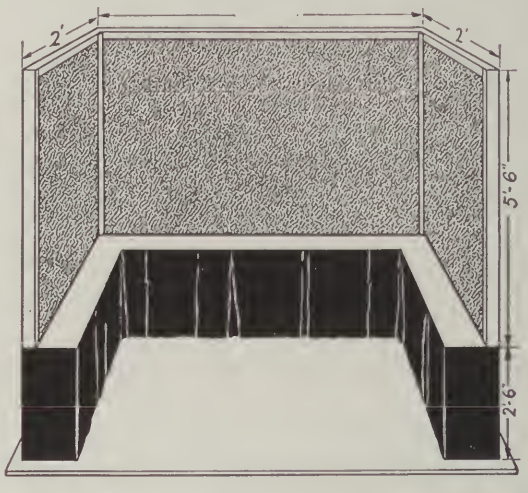
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Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

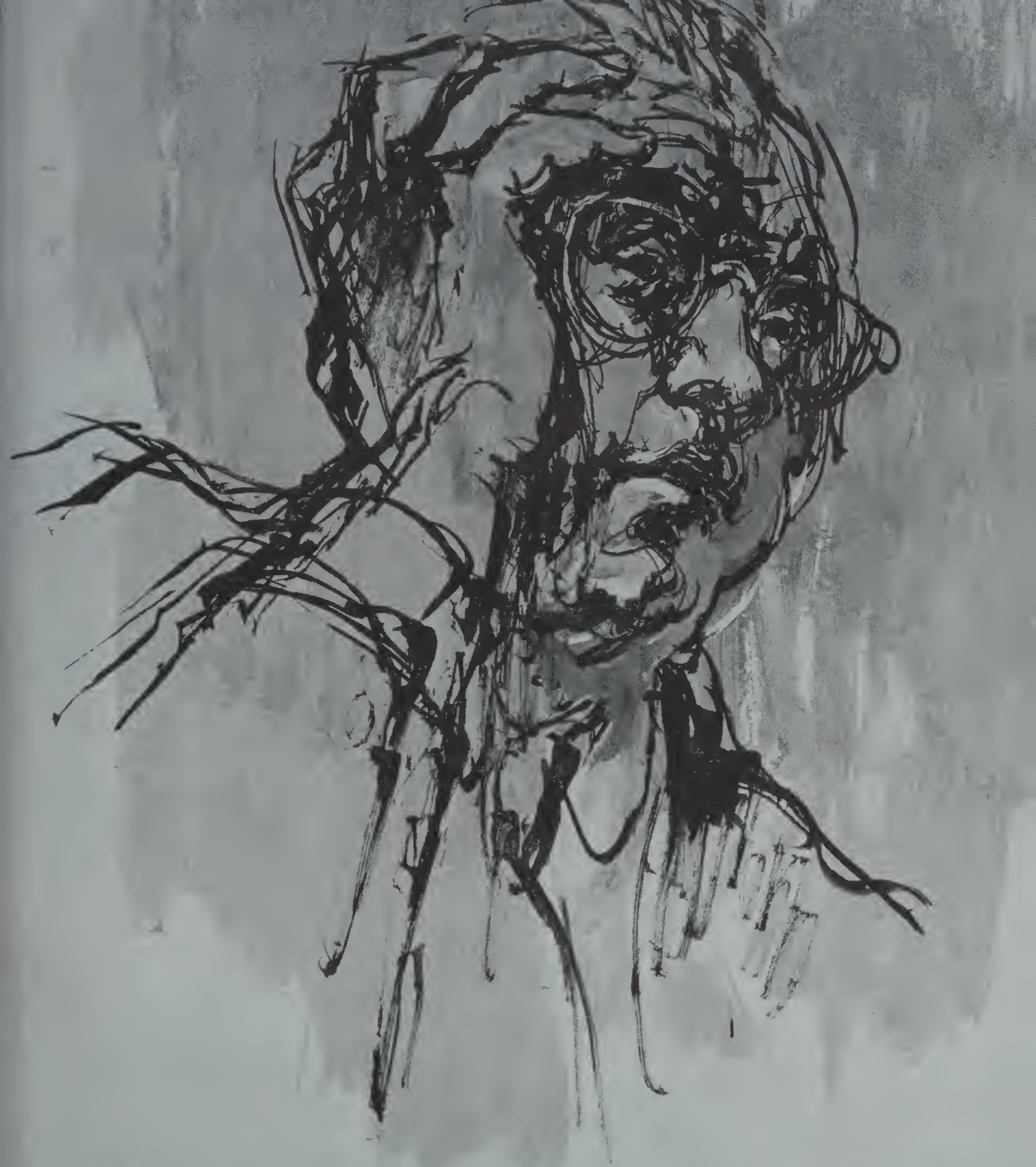
6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

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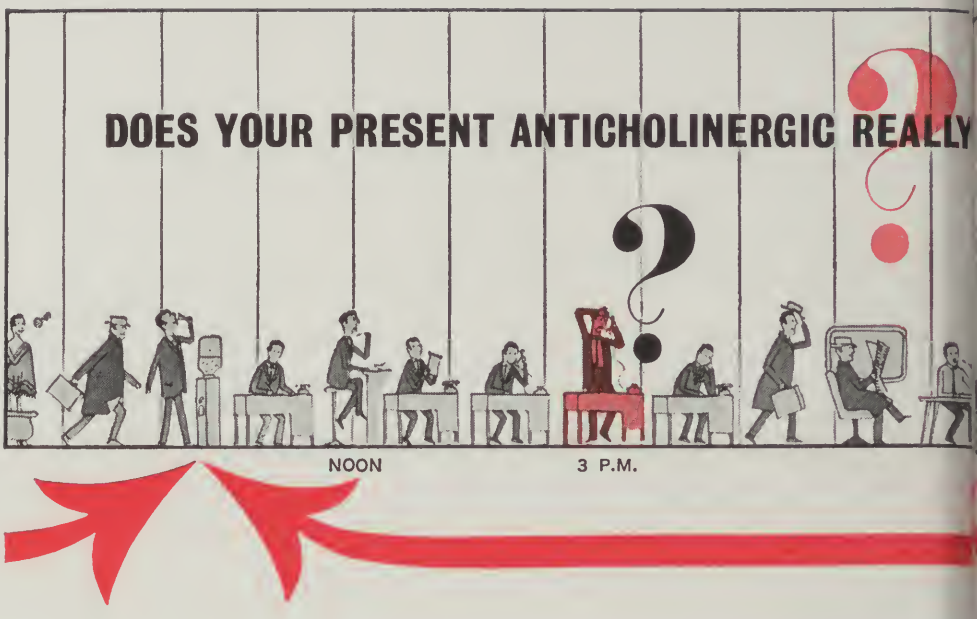
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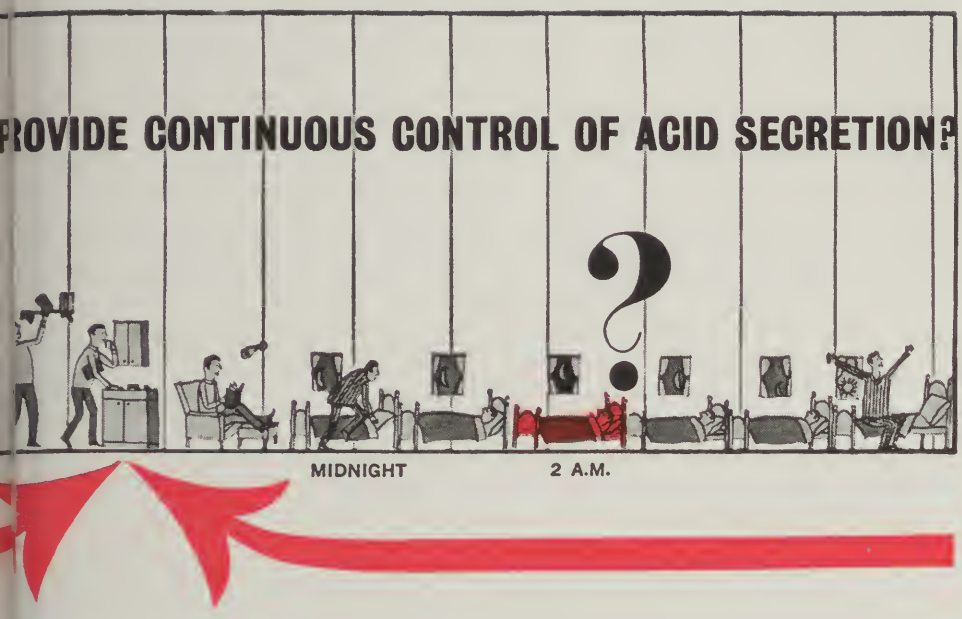
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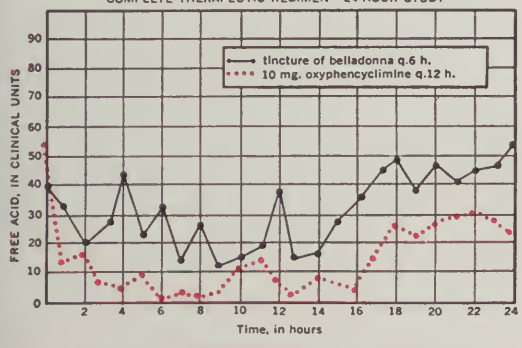
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References: 1. McHardy, G., et al.: J. Louisiana M. Soc. 111:290 (Aug.) 1959. 2. Stelgmann, F.: Study conducted at Cook County Hospital, Chicago, Illinois, in press. 3. Kemp, J. A.: Antibiotic Med. & Clin. Therapy 6:534 (Sept.) 1959. 4. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 5. Data in Roerig Medical Department files.

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Significance of complementary action of isomers in SYNCILLIN

The antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than that of either of its two component isomers alone against many important pathogens, including some penicillin-resistant staphylococci. This phenomenon has been described as *Isomeric Complementarity*.

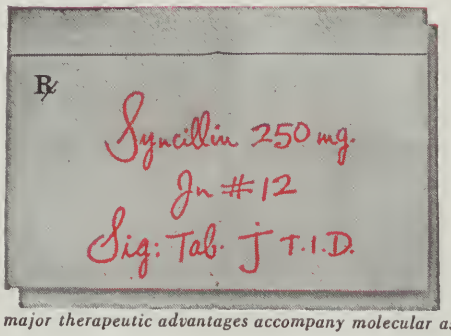
Significance of higher blood levels with SYNCILLIN

Higher blood levels may be of value with organisms of only moderate penicillin sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition, these higher levels may be necessary where there is infection in areas with a poor blood supply. Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue. Also, antibiotic activity of SYNCILLIN is directly proportional to oral dosage. Increasing the dosage may, therefore, enhance the drug's effectiveness in certain cases.

Efficacy of SYNCILLIN against staphylococci and other resistant organisms

Studies have shown that SYNCILLIN is effective *in vitro* against a higher percentage of hospital "staph" strains, than penicillin G and penicillin V.[1,2] Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN might be expected to be somewhat more effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal[3] and gonococcal[4,5] infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



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Relation of intermittent high blood levels of SYNCILLIN to antibacterial efficacy

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations may be sufficient to permit complete eradication of sensitive pathogens. According to Eagle,[6] "Soon after penicillin attains effective concentrations, the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective. . . . The therapeutic significance of this postpenicillin recovery period is enhanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process *in vivo* continues for many hours after the drug itself has fallen to ineffective concentrations."

Reduced rate of inactivation of SYNCILLIN by staph penicillinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be more slowly inactivated by this enzyme than penicillin V or penicillin G. Penicillinase from *B. cereus* likewise inactivates SYNCILLIN less rapidly than penicillin V or G.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective *in vitro* against certain strains of staphylococci resistant to other penicillins. SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. *Therefore, the usual precautions for oral penicillin therapy should always be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.

If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Wright, W. W.: Microbiology Report to Bristol Laboratories Inc. 2. Morigi, E. M. E.; Wheatley, W. B., and Albright, H.: Paper presented at the Seventh Antibiotic Symposium, November 4-6, 1959, Washington, D.C. 3. Editorial: New England J. Med. **261**:305 (Aug. 6) 1959. 4. King, A.: Lancet **1**:651 (March 29) 1958. 5. Epstein, E.: J.A.M.A. **169**:1055 (March 7) 1959. 6. Eagle, H. and Musselman, A. D.: J. Bact. **58**:475, 1949.

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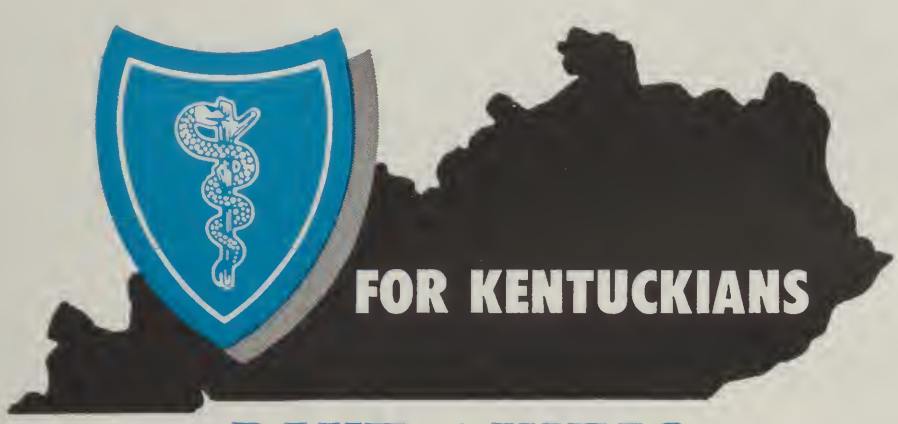
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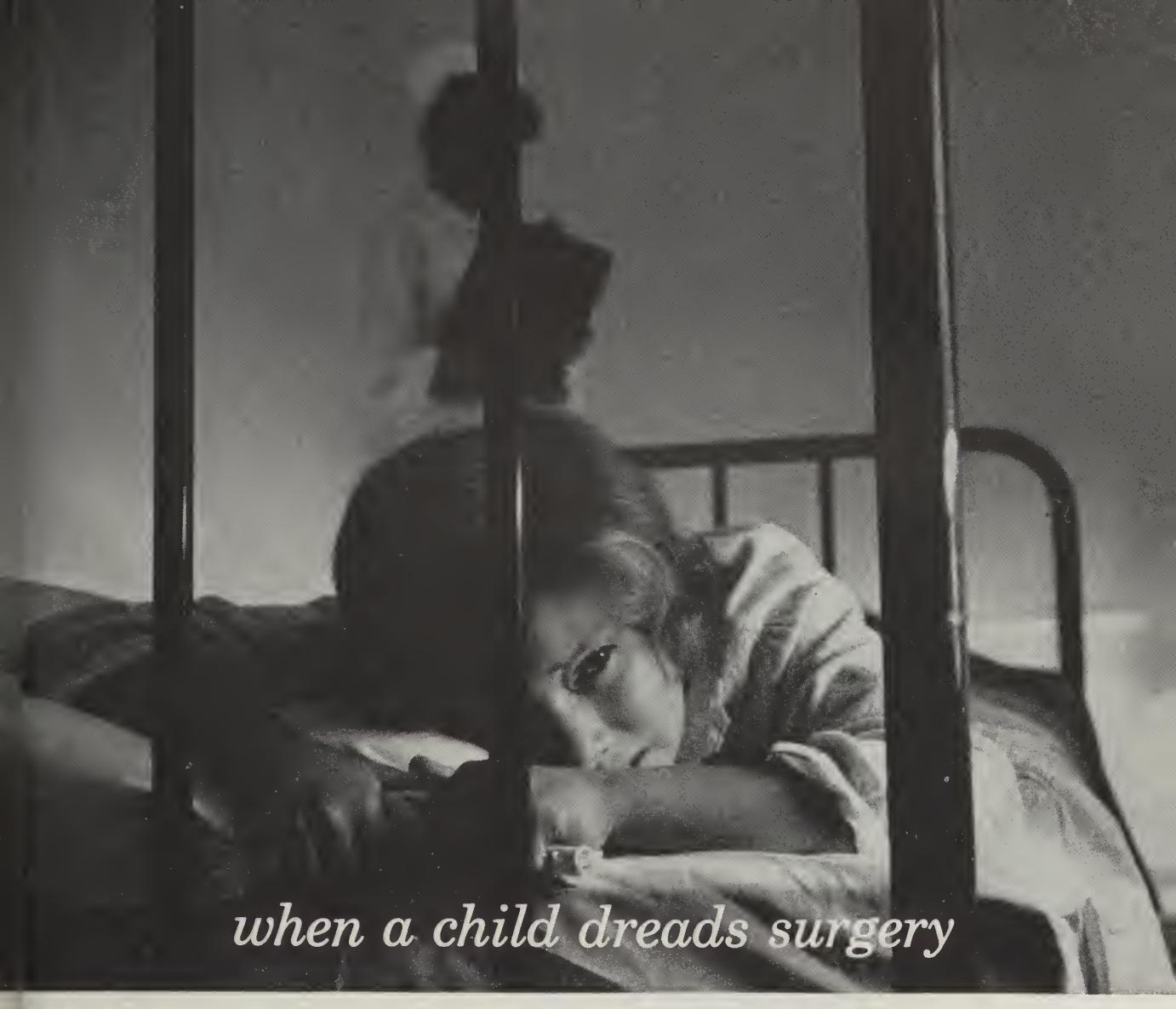
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The Yale School of Medicine will celebrate its sesqui-centennial on October 28-29 with a program of meetings, exhibitions and addresses. Among a notable group of guest speakers will be Sir Howard Florey of Oxford, England. Other events will take place during the 1960-61 academic year, including an exhibition of medical art at the Yale Art Museum and a scientific meeting to be held in conjunction with the dedication of a new medical school auditorium. The Yale School of Medicine, the fifth medical school in the United States, came into being in October, 1810, under a charter granted to Yale College by the Connecticut General Assembly.



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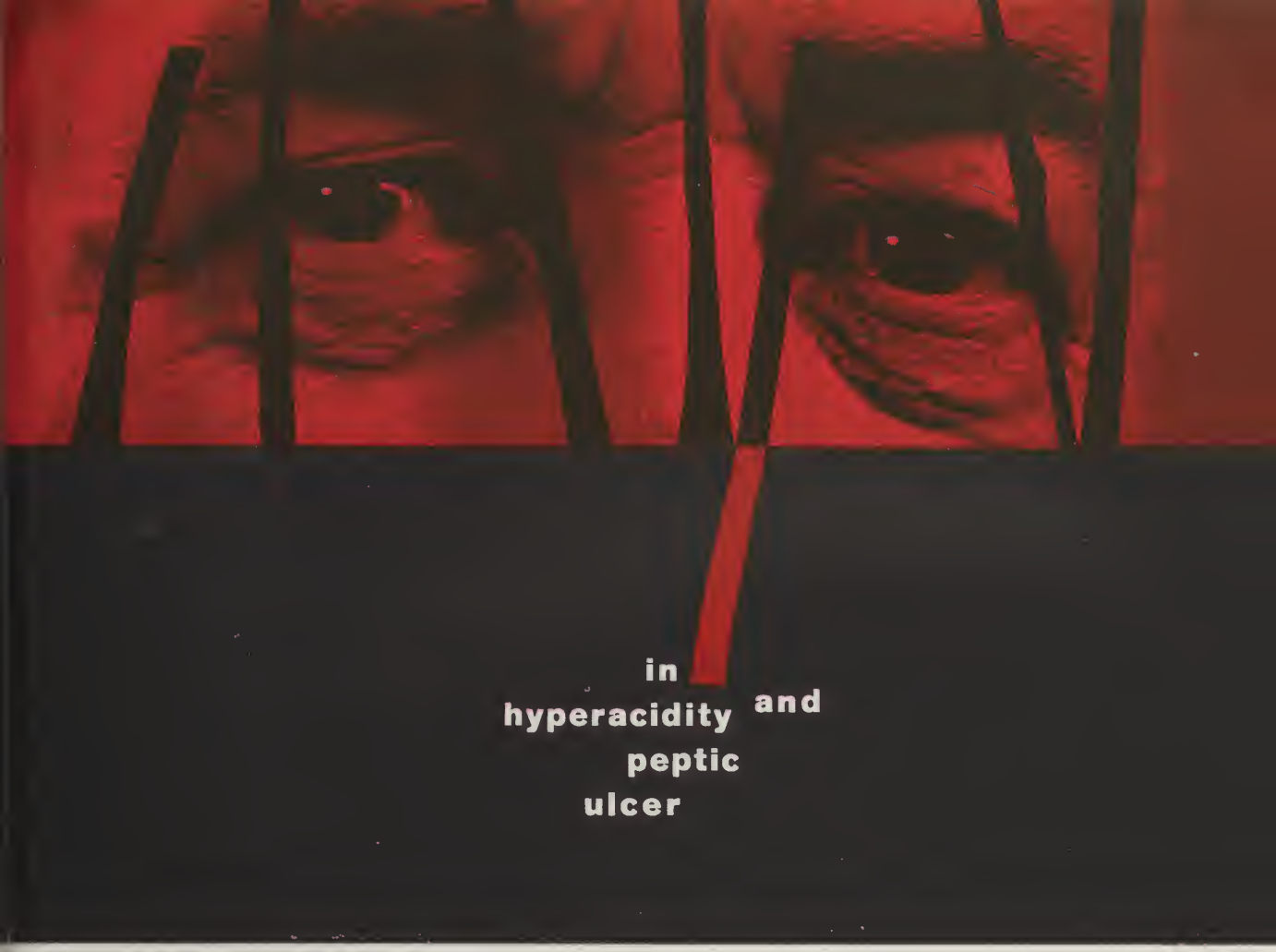
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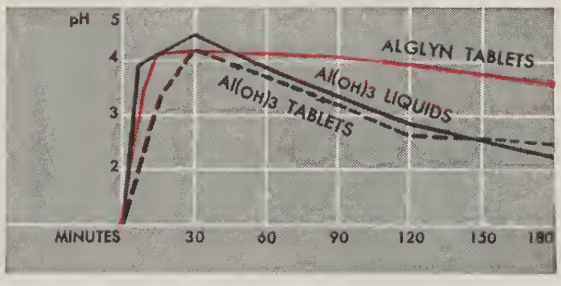
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Robert C. Long, 806 Heyburn Building, Louisville	Jan. 1, 1959-Dec. 31, 1960
George P. Archer, Prestonsburg (Alternate)	Jan. 1, 1959-Dec. 31, 1960

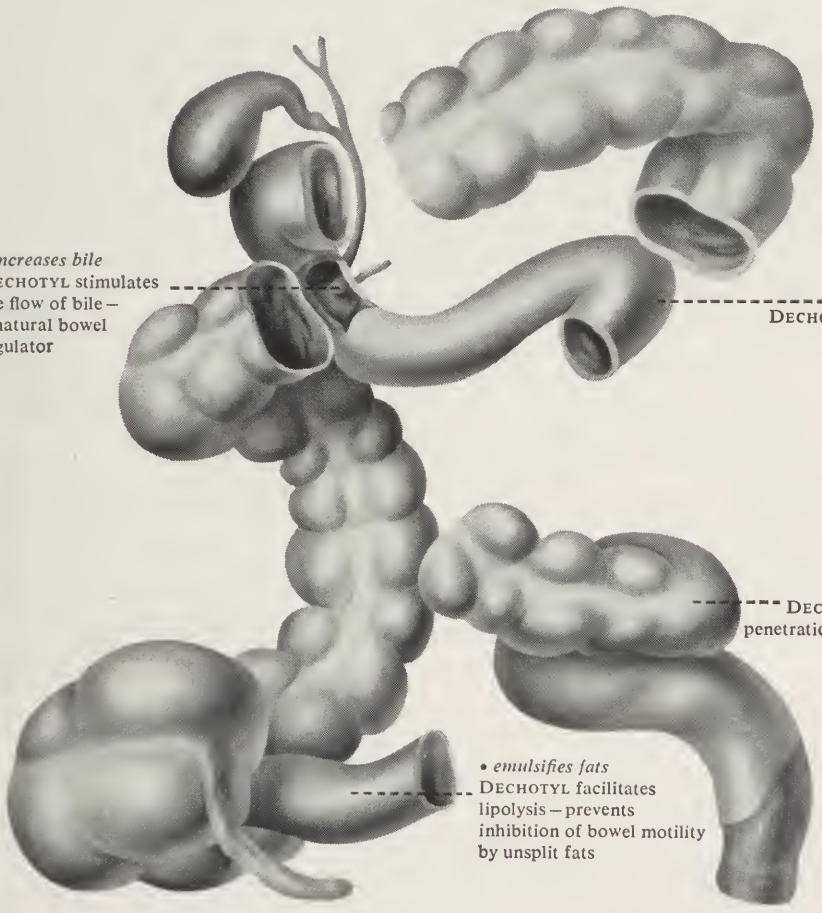
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Bibliography: *(1) Maltby, G. L.:* J. Maine M. A. 48*:257, 1957. (2) Bray, P. F.:* Pediatrics 23*:151, 1959.*

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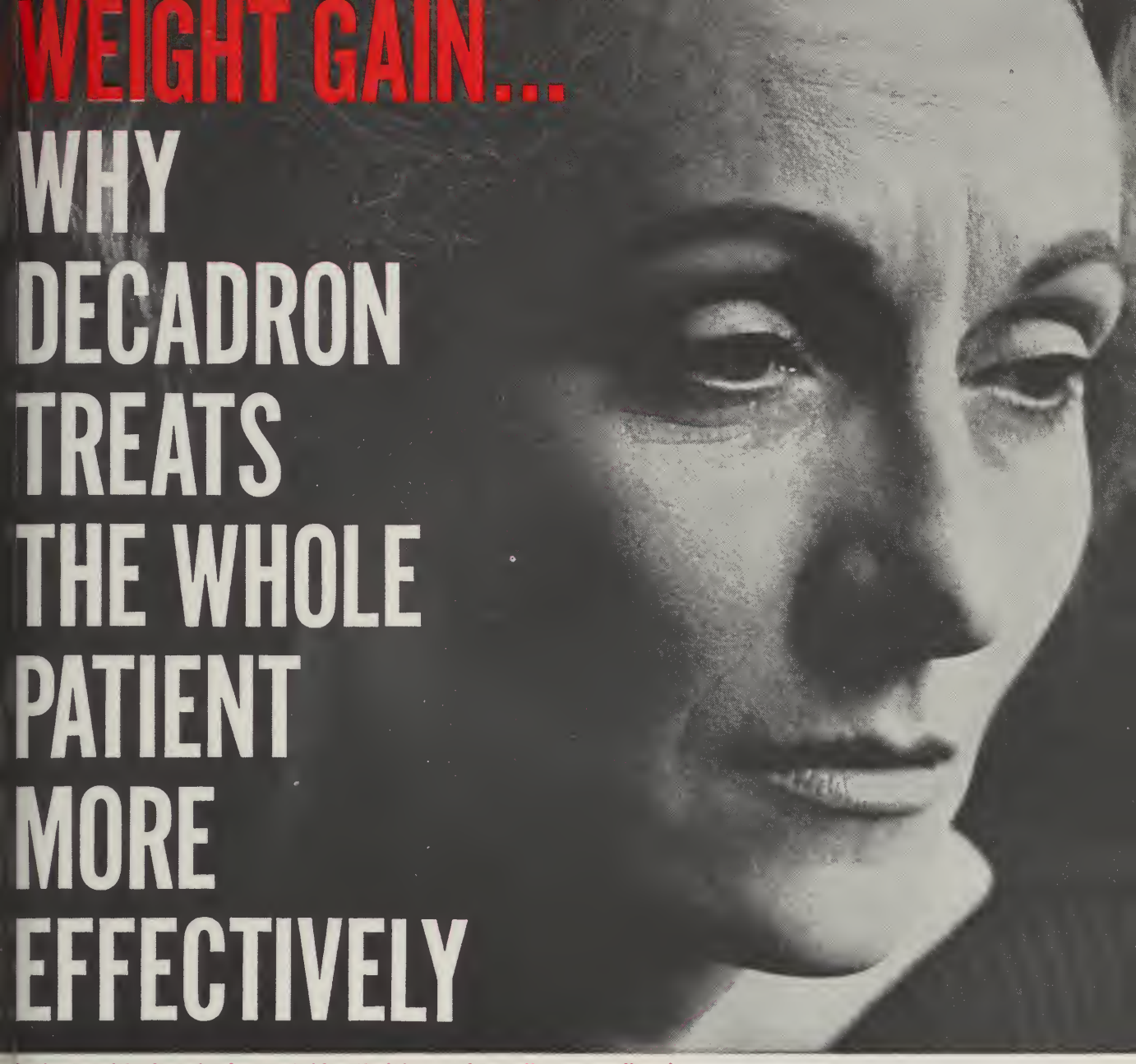
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References: 1. Bunim, J. J., et al.: Arthritis & Rheumatism *1*:313, 1958. 2. Silverman, H. I., and Urdang, A.: Am. Prof. Pharm. *25*:531, 1959. 3. Rudolph, J. A., and Rudolph, B. M.: Ann. Allergy *17*:710, 1959. 4. Spies, T. D., et al.: South. M. J. *51*:1066, 1958. 5. Galli, T., and Mannetti, C.: Minerva med. *50*:949, 1959. 6. Segal, M. S., et al.: Ann. Allergy *17*:413, 1959. 7. Duvencl, J., et al.: Ann. Allergy *17*:695, 1959.

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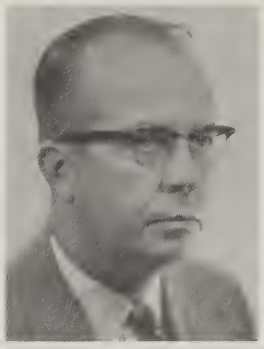
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Dr. Preston
Vice-President—Eastern

President's Page*

The Relative Value Scale

THE majority of physicians in our state are, I am sure, in complete agreement that the Forand type of legislation poses a real threat of destruction to our own system of private practice; yet we seem divided in our thinking regarding two other plans which I think are equally dangerous: namely, the service type of insurance coverage and the Relative Value Scale. The arguments for and against the former have been well covered in a previous issue of the Journal, and I will confine my remarks to the Relative Value Scale.

The proponents of the Relative Value Scale tell us that it is not a mechanism for fixing fees, but what else can it be? As soon as a conversion factor is applied, it does become a fixed fee and we are then under regimentation, either of our own making or under federal control. It would give labor, government, or any other third party a powerful weapon to bargain down our fees.

The proponents of the Relative Value Scale feel that it is necessary to change our own system in order to meet the "changing economic climate of the times." Isn't it better that we take our stand now and say "No!" to this regimentation? We know what happens once the door is open, as shown by the snowballing of our Social Security system.

The argument that it will better enable insurance companies to set up more realistic fee schedules doesn't seem valid. Their fee schedules are already established from their experience tables.

It seems entirely likely that a Relative Value plan can divide doctors into three classes: those charging the scale, those above, and those below. Those below would be looked upon as "cheap"; those above, as "fee gougers."

Let us give this problem serious consideration and not hastily adopt something of our own making which would be as bad as federal control. Even though some states have adopted it and it seems to be the trend, that doesn't prove that it is the correct course for us. Let us not wake up regretfully to the realization that we have voluntarily given away another freedom.

W. O. Preston, M.D.
Vice-President—Eastern

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Diagnostic Quandaries

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Chronic Appendicitis?
Rheumatoid Arthritis? Regional Enteritis?

A DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.[1]

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica*. In 15 of these subjects, nine stool specimens were required to establish the diagnosis.[2]

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.[3]

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2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. *9*:897 (June, 1958).

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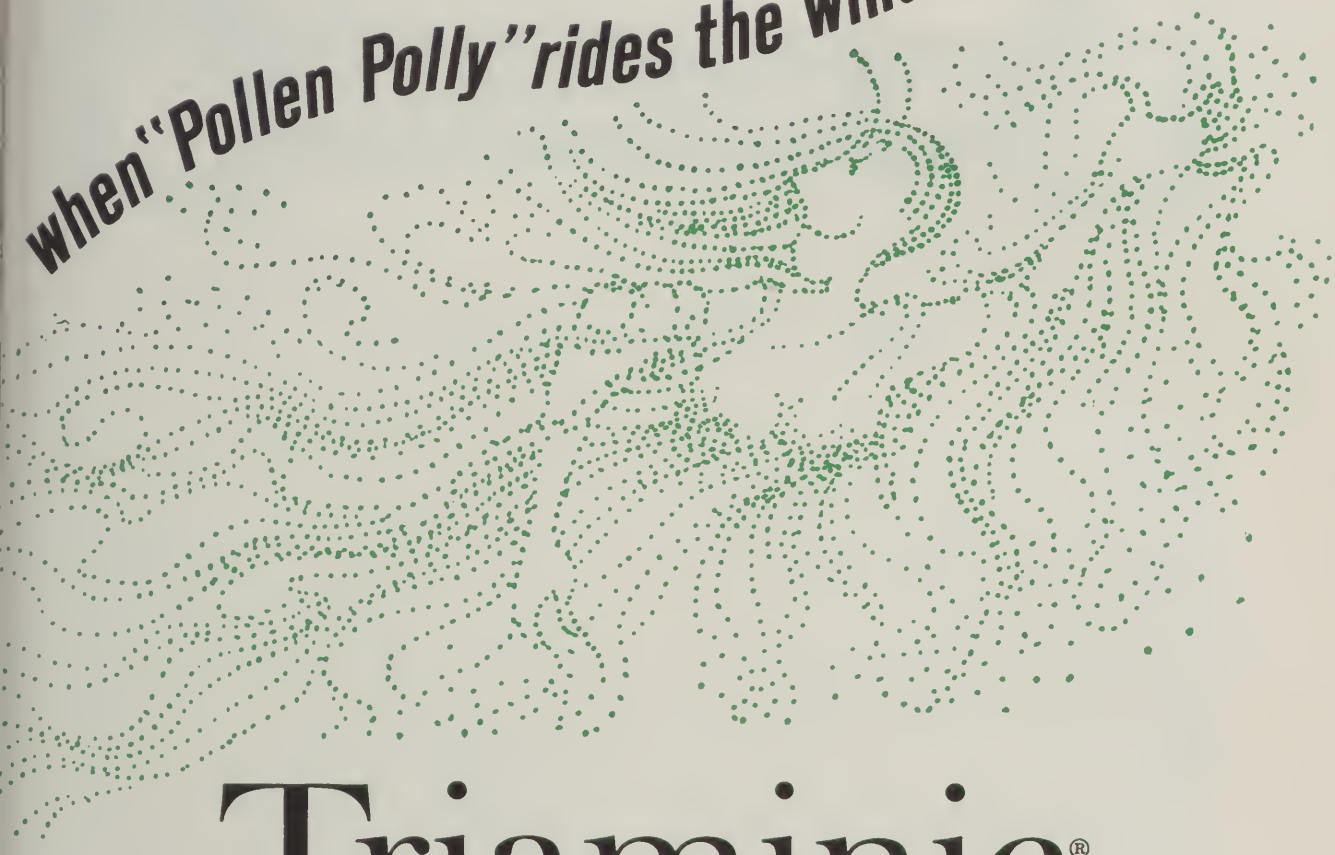
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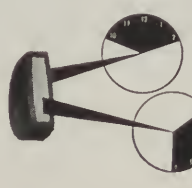
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THE INSURANCE PAGE



What Do You Mean—'Non-Profit?'

ONE of the chief distinctions between medically sponsored prepayment plans, such as Blue Shield, and the commercial health and accident insurance companies is that Blue Shield is conducted on a "non-profit" basis, whereas the insurance companies are frankly business enterprises operated to earn a profit for their owners.

To emphasize this difference is not to imply criticism of either. The insurance companies have a long and honorable history of public service and they are an important part of America's business community.

Blue Shield, on the other hand, serves largely as an agency of the medical profession, performing a community service. Initiated by the medical profession, with the help of local industry, labor and civic leaders, Blue Shield is designed for one purpose only: to help people pay for medical services whenever the need for such service arises.

Blue Shield Dared the Risk

As the Blue Shield is a non-profit organization, it is also tax free. For these two reasons, carrying costs are smaller than those of commercial insurance companies. This has led to the cry of unfair competition, a complaint that is not justified. The Blue Shield Plans developed of necessity because commercial insurance companies did not dare the risk of a new and untried field. Blue Shield pioneered the venture and then commercial insurance companies, finding it a feasible enterprise, came in with a vigor.

Blue Shield has succeeded in developing the medical care prepayment movement because the profession has guided it and supported it. Blue Shield's working capital was the pledge of the participating physician to deliver the medical services that Blue Shield has promised on his behalf.

In some cases, the participating physicians have accepted a fraction of scheduled Blue Shield payments in order to tide an infant plan over its early trials. In every case, local professional leaders have given their Blue Shield Plans incalculable hours of service as trustees and advisers. None has ever accepted one penny of compensation for these services. As an agency of the medical profession, created for the sole purpose of aiding the doctor in serving his patients, there has been no thought of a "third party" to make a profit out of the Blue Shield operation.

Success Brings Wider Coverage

Blue Shield's success is measured by the proportion of its income dollar spent for the services to its subscribers, the low operating costs, and the ever increasing funds which are being made available for wider coverage.

The Blue Shield operation does earn money; however, these earnings are plowed back into the organization instead of being dispersed as dividends. Both patient and doctor profit by the steadily expanding coverage that is being developed as our reserves are accumulating.

Our Kentucky Blue Shield Plan was started in 1949. As of December 31, 1959, there were 621,303 members in Blue Shield, and in 1959 Kentucky physicians received $5,041,334 for service to members. There are 73 Blue Shield Plans in 44 states, the District of Columbia and eight Canadian provinces. In the United States there are 42,256,807 persons enrolled in Blue Shield Plans, which is 24% of the total population. This is in comparison with 10 years ago. At the end of 1949 there were 12,260,045 persons enrolled.

Kentucky's Elderly Included

Recently in Kentucky, as in the majority of other Blue Shield Plans, and in response to a resolution passed by the American Medical Association in 1958, a contract was arranged for eligible persons 65 years of age and older. This was first offered to these people on November 15, 1959, by the Kentucky Physicians Mutual, Inc. In the enrollment period of two weeks 775 applications for this contract were approved.

The interested insight into, the intelligent guidance and loyal support of, and the kindly cooperation with your Kentucky Blue Shield Plan is urged of all Kentucky physicians because this indemnity plan was established for the benefit of both patient and physician alike and therefore deserves the support of both, throughout this our Commonwealth of Kentucky.

Branham B. Baughman, M.D.

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1. Projection from Vital Statistics, U.S. Government Dept. HEW, Vol. 48, No. 14, 1958, p. 398.
2. Modell, W.: Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.

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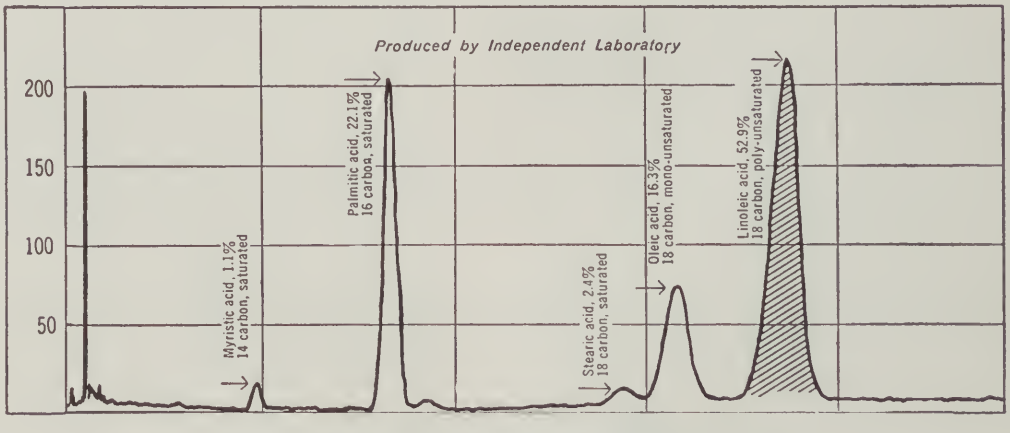
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A significant statement about serum cholesterol and dietary fats

"It is now well recognized that serum cholesterol levels in man can be lowered by the judicious substitution of one type of dietary fat for another. However, it is relevant to inquire whether a patient can be assured that such a radical change in his dietary habits will prevent coronary occlusion or a cerebral vascular accident. This question must unfortunately be answered in the negative, for it has not been proved that lowering the level of serum cholesterol will prevent either the occurrence or the end-results of atherosclerosis. At the present time, clear proof of this proposition still seems many years away. Nevertheless, there are many reasons for believing that there is some connection between cholesterol metabolism and atherosclerosis, and, while waiting for elucidation of this relationship by laboratory workers, it seems justifiable to apply certain dietary procedures that are theoretically harmless and possibly beneficial."

Excerpted from J.A.M.A., Aug. 29, 1959

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Total unsaturated	70-75%
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Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, Wesson is unsurpassed by any readily available brand.

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*Reconfirmed by recent tests against the next leading brand with brand identifications removed, among a national probability group.

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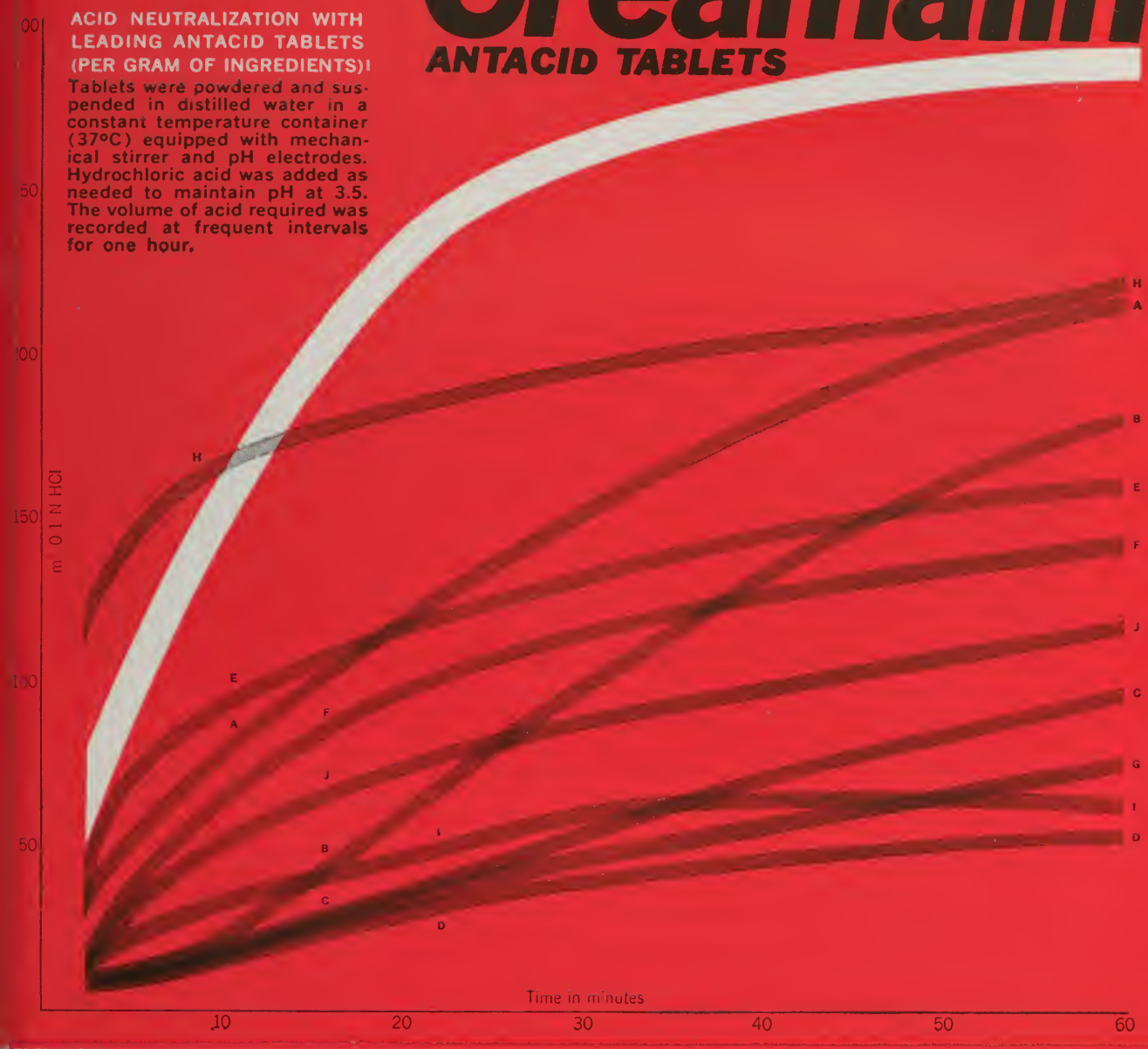


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1. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:380, July, 1959. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:384, July, 1959.

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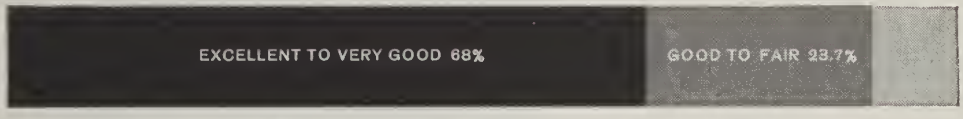
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1. Kestler, O.: In The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. 2. Berger, F. M.; Kletzkin, M.; Ludwig, B. J.; Margolin, S., and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 3. Spears, C. E. and Phelps, W. M.: Arch. Pediat. *76*:287 (July) 1959. 4. Phelps, W. M.: Arch. Pediat. *76*:243 (June) 1959. 5. Friedman, A. P.; Frankel, K., and Fransway, R. L.: Papers presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 6. Kuge, T.: Unpublished reports. 7. Ostrowski, J. P.: Orthopedics *2*:7 (Jan.) 1960.

Literature and samples on request

Also available on request: The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. (185 pages)

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WASHINGTON NEWS DIGEST

Washington, D. C.—Defeat of the Forand bill in the House Ways and Means Committee highlighted developments on the issue of legislation to provide more federal health care for the aged.

The committee voted 17 to 8 on March 31 to shelve the Forand bill which would increase Social Security taxes to provide surgical benefits and limited hospitalization and nursing home care for Social Security beneficiaries, except the disabled.

However, the issue remained very much alive.

Alternative Proposals Considered

The Eisenhower Administration and Congressmen were separately considering various alternative proposals to provide additional health care for the aged, but outside the Social Security system. And the action of the House Committee did not rule out the possibility of Forand-type legislation being brought up in the Senate later this session.

The House Committee vote against the Forand bill came during the drafting of an omnibus measure of revisions in the Social Security program. The committee voted tentatively to bring physicians under Social Security.

The committee also favored elimination of the requirement that a disabled person must be 50 years or older to be eligible for Social Security payments.

Aid to States Proposed

Arthur S. Flemming, Secretary of Health, Education and Welfare, said the Administration was considering a plan for federal payments to the states to help needy old persons buy private health insurance on a voluntary basis. He said he hoped the plan would be ready for submission to Congress by late April.

Sen. Jacob K. Javits (R., N. Y.) and seven other Republican Senators introduced similar legislation in the Senate. The bill called for the Federal Government and states jointly putting up about $1 billion a year to help persons 65 years and older, and their spouses, to buy private health insurance. The coverage would include physicians' care in home and office, diagnostic services, hospitalization and nursing home care.

Another plan being considered by some other members of Congress would broaden the federal-state public assistance program to provide more health care for needy older persons.

Both President Eisenhower and Vice President Nixon reiterated their opposition to any compulsory health plan such as the Forand bill. The President told a news conference that such plans would be a definite step toward socialized medicine. He proposed that medical care for the aged be improved through further development of voluntary health insurance programs.

Vice President Nixon gave his position in a letter to physicians who had communicated with him about the matter.

"The Vice President, throughout his career as a public official, has consistently opposed and will continue to oppose any compulsory health insurance program," the letter said. "This, of course, includes the Forand bill..."

"He believes that the best way to handle the problem of people over 65 who do not have and cannot afford health insurance is through a program which will enable those who desire to do so to purchase health insurance on a voluntary basis."

On the other side, three candidates for the Democratic nomination for President—Senators John F. Kennedy (Mass.), Hubert H. Humphrey (Minn.) and Stuart Symington (Mo.)—said they would push for passage of Forand-type legislation.

AMA Attacked

The AFL-CIO continued its all-out campaign in support of the Forand bill. Leaders of the labor union repeatedly attacked the American Medical Association for opposing the bill.

One of the attacks prompted Louis M. Orr, M.D., Fla., to protest in a letter to AFL-CIO President George Meany against the union's "deliberate distortions of the truth, perversions of the truth, and outright untruths."

Doctor Orr charged that allegations in a political memorandum of the AFL-CIO's Committee on Political Education (COPE) "not only... attempt to impugn the motives and competence of the nation's physicians, but they seek to mislead labor's rank and file, the members of Congress, and the American people as a whole."

"When the AMA opposes any legislative health measure, it does so because its members believe that it would lead to poorer—not better—health care for the people of this country," Doctor Orr said.

AMA Defended

Senate Republican Leader Everett M. Dirksen (Ill.) also defended the AMA, as well as the Eisenhower Administration, against the attacks when AFL-CIO leaders repeated them in testimony before the Senate Subcommittee on Problems of the Aged and Aging.

Senator Dirksen denounced them as "gratuitous slurs," "stinking statements," "invidious... insane

(Continued on Page 640)



in infectious disease[17,22,30,3
in arthritis[18,19,20,2
in hepatic disease[2,3,4,5,3
in malabsorption syndrome[1,2,6,2
in degenerative disease[6,7,19,20,4
in cardiac disease[23,28,29,38,4
in dermatitis[24,3
in peptic ulcer[8,21,3
in neuroses & psychiatric disorders[25,2
in diabetes mellitus[31,32,33,3
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*pHisoAc, trademark.

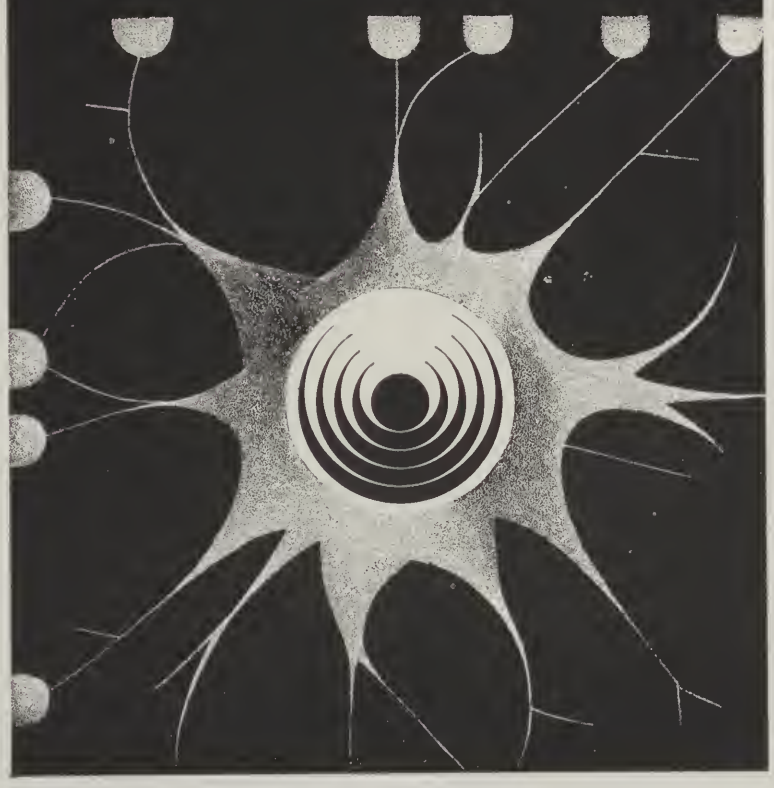
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References: 1. Ayd, F. J., Jr.: Bull. School Med., Univ. Maryland *44*:29, 1959. 2. Azima, H., and Vispo, R. H.: A.M.A. Arch. Neurol. & Psychiat. *81*:658, 1959. 3. Lehmann, H. E.; Cahn, C. H., and de Verteuil, R. L.: Canad. Psychiat. A. J. *3*:155, 1958. 4. Mann, A. M. and MacPherson, A. S.: Canad. Psychiat. A. J. *4*:38, 1959. 5. Sloane, R. B.; Habib, A., and Batt, U. E.: Canad. M.A.J. *80*:540, 1959. 6. Straker, M.: Canad. M.A.J. *80*:546, 1959. 7. Strauss, H.: New York J. Med. *59*:2906, 1959.

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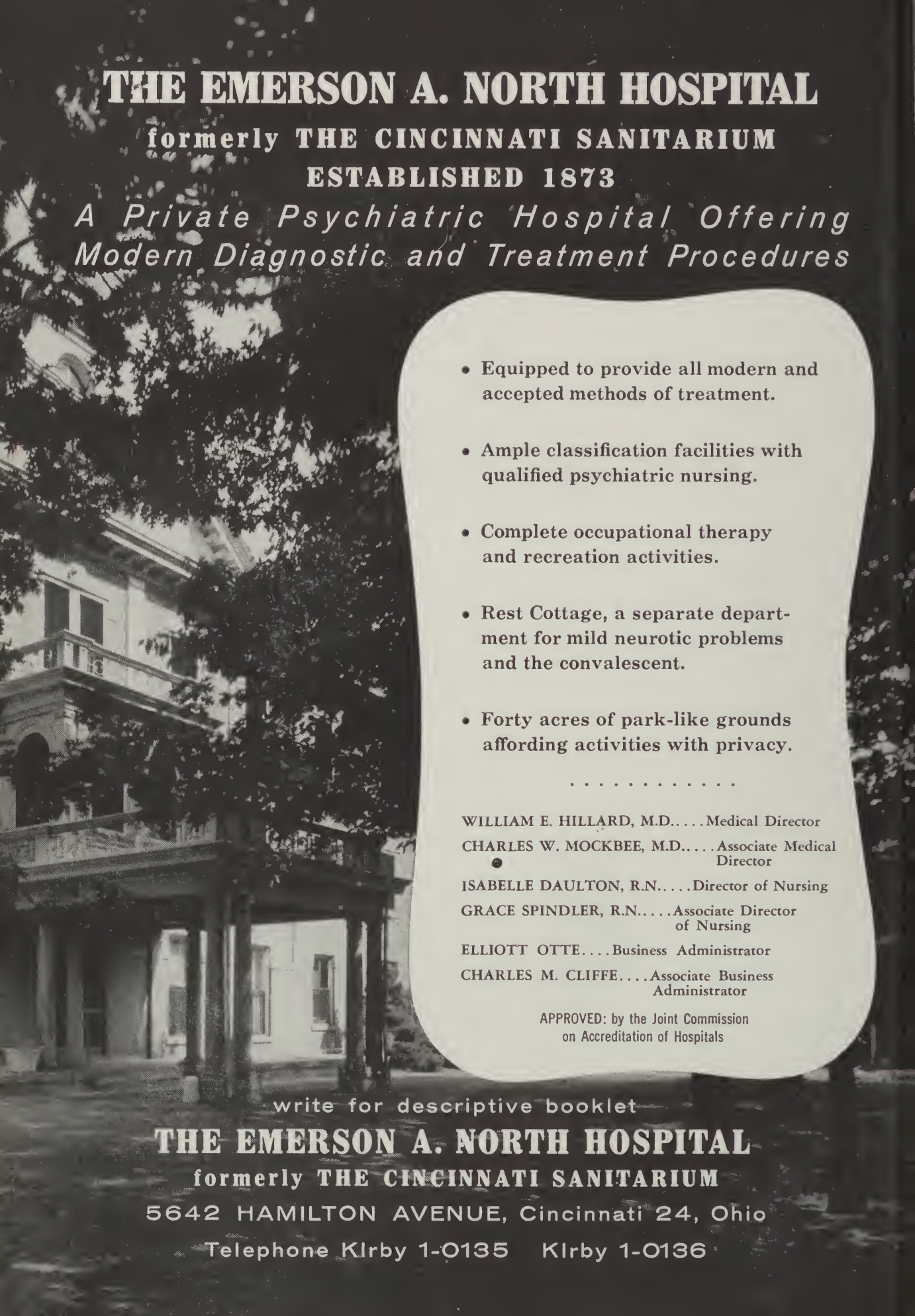
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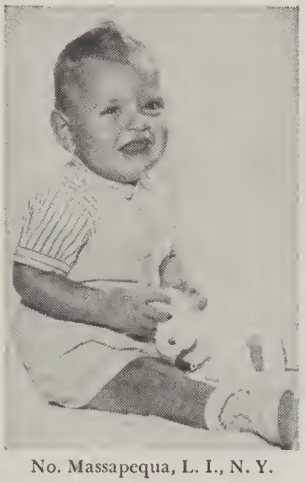
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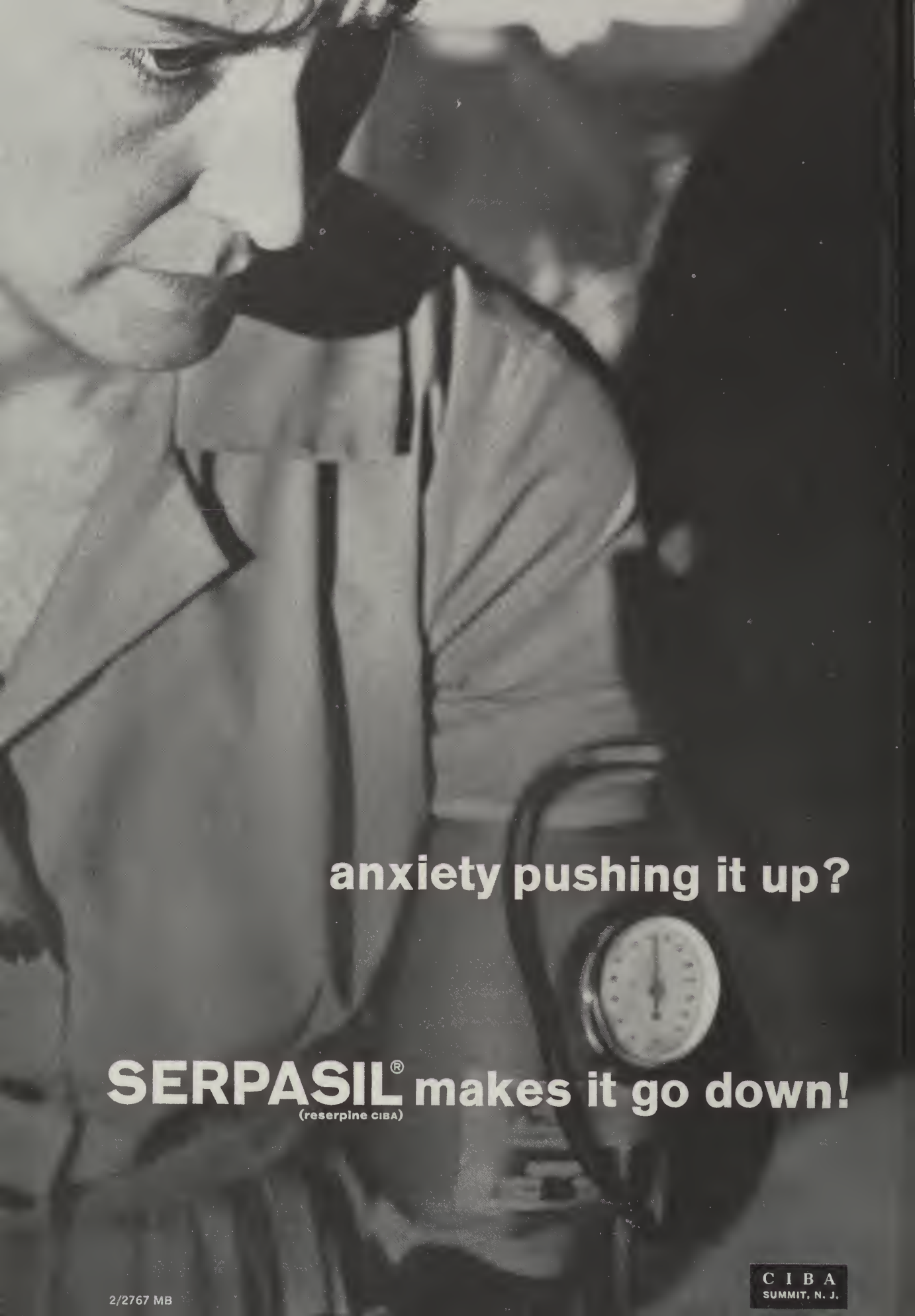
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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

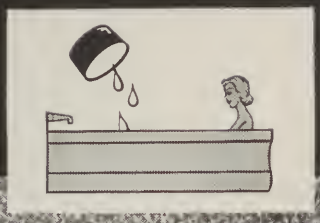
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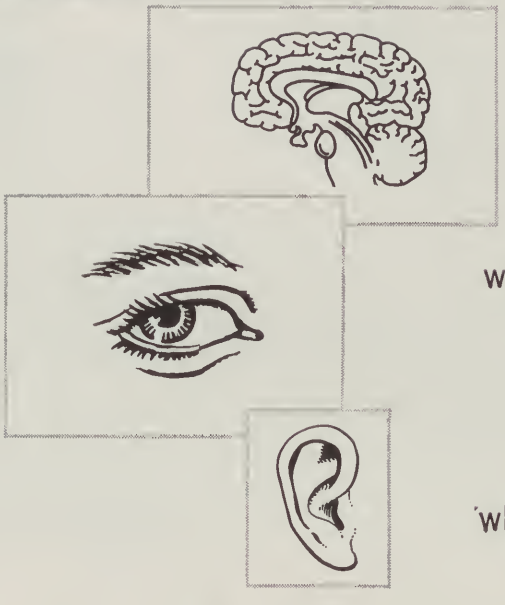
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Prostatic Malignancy*

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The value of careful digital examination of the prostate in men over 50 is strongly emphasized. The avenues of therapy presently available are discussed

The prostate gland, aside from its normal physiological function, is important because of three fundamental kinds of pathology, all of which occur singly or in any combination:

1. **Prostatitis,** including the following types:
   a. Bacterial prostatitis, which as a result of chronic inflammation and scarring can cause a palpable and sometimes irregular induration in the gland.
   b. Congestive or catarrhal prostatitis, with symptoms mainly from poor evacuation.
   c. Calculous prostatitis, usually associated with bacterial inflammation, often presenting the examining finger with a confusing localized hardness.
2. **Benign prostatic hypertrophy,** occurring eventually to some extent in perhaps a third to half of all men.
3. **Prostatic malignancy,** usually adenocarcinoma, eventually results in death if not surgically removed.

How common is prostatic carcinoma? It's difficult to tell exactly without mandatory postmortem examinations. Several statistical summaries, however, are available from routine consecutive autopsy studies in several medical centers, and these show an incidence in men over age 50 of from 14-46%—a really staggering figure. Of males dying of any cancer, it appears to be second only to cancer of the stomach. If any of us were to live long enough we probably would ultimately end up with cancer of the prostate.

Diagnosis

Early cancer of the prostate is completely lacking in symptoms, which is the main reason most people who have the disease are not cured. By early cancer we mean it is localized to perhaps not over 2 cubic centimeters within the prostate and with very little question susceptible to complete surgical removal. Beyond this stage it begins to bulge the prostate, invading its capsule, and causing symptoms of prostatism which may make the patient seek examination. At this stage, surgical cure is uncertain but is yet well worth considering in the absence of

*From the Section on Urology, Department of Surgery, University of Louisville School of Medicine.

demonstrable metastases. The late stages are characterized by variable symptoms of prostatic obstruction and by the symptoms of metastases, commonly intractable bone pain, anemia and, occasionally, uremia from occlusion of ureters.

Rectal examination may yield good evidence of cancer. The posterior surface of the prostate is easily palpable through the anterior rectal wall, and carcinoma usually arises in the posterior portion of the prostate, called for convenience the posterior lobe. The malignant tissue is characteristically hard and often heaps up in a knotty bulge. So the examining finger is the first line of defense and diagnoses thus made are accurate about 80% of the time.

However, both the induration of chronic prostatitis and prostatic stones, and even occasionally a small benign adenoma of the prostate may arouse suspicion that later biopsy shows unwarranted. It is best, therefore, to prove the diagnosis by tissue examination before undertaking radical surgery that may be unnecessary.

Verification of Diagnosis

There are four means of verifying the diagnosis of carcinoma. First expert examination of a Papanicolaou stained smear of prostatic secretion obtained by massage. There are not many experts available to interpret these slides, and at best this method appears to be only about 60% accurate, which leaves it outclassed by even the examining finger. So, few people are very enthusiastic about this method.

A second method is by transurethral resection. This is quite satisfactory for diagnosis and treatment of extensive and otherwise inoperable prostatic carcinoma, but it is not reliable for the small localized area and has the disadvantage of stirring up considerable inflammatory response, which makes radical prostatectomy more difficult if the resected tissue turns out to be malignant.

A third and rather popular method of getting tissue is by needle biopsy, either transperineally or transrectally. This is almost an office procedure and gives up to 80-90% accuracy, particularly with multiple biopsies. However, with small prostates with small suspicious areas it is difficult to get an adequate specimen by needle puncture, much less to hit the exact suspicious area. One is often left in the situation of operating if the biopsy is positive, or not yet knowing for sure if it is negative.

The fourth method we recommend and use in most instances is open perineal biopsy through the same perineal incision necessary to remove the prostate. This exposes the whole posterior surface of the prostate, and generous wedge biopsies can be taken from several areas under direct vision and palpation and the question settled for certain right then. A pathologist who is skilled in interpreting frozen sections may then give the answer in a few minutes and radical perineal prostatectomy may be done under the same anesthesia, or else the wound may be closed and the patient sent home two or three days later. If we conscientiously biopsy all suspicious prostates, we probably should have at least 20% showing no sign of cancer. So much for diagnosis.

Curative Surgery

Now a word about radical surgical removal, the only chance for cure presently known. Two operations are currently used, both completely removing the prostate with its capsule, seminal vesicles and some tissue about them, and a generous rim of bladder neck. The perineal route, mentioned above, has the advantage of using the same incision developed for the open perineal biopsy, of avoiding the rich vascular plexus anterior to the prostatic capsule, and of permitting more accurate anastomosis of bladder neck to membranous urethra at the conclusion of the operation. It becomes technically more difficult if the prostate is large enough to hamper ultimate dissection through the limited exposure of the perineal wound, and in this event we prefer the retropubic operation.

Needless to say, urologists vary considerably in their enthusiasm for one or the other of these approaches. Properly done, the mortality is no greater than in simple prostatectomy, although morbidity may be longer.

The usual open prostatectomy for the relatively common, large, obstructing benign prostate is a subcapsular enucleation, leaving behind the capsule which can be closed as a layer of the wound. We know that the posterior capsule, actually a part of the posterior lobe, is often the site of origin of prostatic malig-

nancy. We know also that simple enucleation, while resulting in excellent restoration of bladder function, also results inevitably in inflammation of the periprostatic tissues with scarring and destruction of tissue planes. Radical prostatectomy attempted perhaps years later for carcinoma in residual capsular tissue may then be greatly complicated and technically impractical. If the chance of developing carcinoma in residual capsular tissue after simple enucleation is 10-15%, which seems a conservative estimate, then why not do radical prostatectomy on every patient needing prostatectomy?

Four Points to Consider

The answer can be deducted from the following: (1) Radical prostatectomy about 10% of the time results in some degree of permanent urinary incontinence which is an almost unacceptable social handicap. (2) Impotence almost always occurs after radical prostatectomy, and even the oldsters occasionally object to this. (3) The need for simple enucleation or resection does not arise until the later decades of life, and on the average carcinoma may not develop for another five years if it does at all. (4) If carcinoma develops in residual tissue, hormonal treatment by estrogens and orchidectomy will usually hold it in check for another 2½ years. The individual is then usually at a point when degenerative diseases of old age have a probability of terminating his existence before the carcinoma has a chance to bother him very much. Consideration of these things, therefore, leads most of us to reserve radical prostatectomy for the patient in relatively good physical condition in whom the diagnosis of carcinoma can be proven ahead of time.

Now, briefly, what can we offer the man presenting inoperable prostatic cancer, inoperable either by reason of local invasion beyond limits, metastases, or by reason of complicating vascular or other infirmities?

We know that prostatic cancer is usually androgen dependent, and that depriving it of androgens results in lessening its temporal malignancy. Bilateral orchidectomy removes about two-thirds of available androgens. Estrogens appear to inhibit pituitary manufacture of gonadotropic hormones and by a different method reduce androgens. On the average, people presenting themselves in this fix will have two years of relatively comfortable living with either of these forms of therapy. There is some evidence that a combination of the two is a little more effective than either alone.

Because of the fact that the adrenal glands are known to supply another third of the androgen supply, bilateral adrenalectomy has been tried to further reduce the sustenance of these malignant cells. But because the symptomatic relief from metastatic pain is usually only a matter of a few months, and because for this small amount of benefit the considerable problems of adrenal insufficiency are created, this rather major operation is not usually advised.

The same results and disadvantages are observed from hypophysectomy, which seeks to completely ablate the source of gonadotropins.

For the obstructive symptoms of inoperable prostatic cancer, we offer transurethral resection of obstructing tissue which usually restores reasonably satisfactory bladder function.

Summary

(1) We strongly emphasize the value of careful digital examination of the prostate in every man over age 50. (2) Means for accurate diagnosis following digitally-inspired suspicion have been described. (3) The avenues of therapy we presently have available have been discussed.

The Rh Factor*

GLENN W. BRYANT, M.D.

Louisville, Ky.

Management of the pregnant Rh negative patient is discussed. The benefits of prompt and repeated exchange transfusion of babies having erythroblastosis are demonstrated

THE importance of the Rh factor in transfusion and pregnancy is now well documented. Investigation of transfusion reactions in recently delivered patients led to the discovery of the factor by Levine and Stetson in 1939. Further investigation led to the discovery of five other related factors which are called the Rh system. These factors have been named D (the original Rh factor), d (the original Rh negative factor), C, c, E, and e.

These factors follow the Mendelian Law of Heredity. Fisher and Race have postulated that there are eight possible chromosomes, each of which carries genes for three factors.

TABLE I
The Eight Basic Chromosomes of Fisher and Race

DCe	(R_1)	dce	(r)
DcE	(R_2)	dCe	(r′)
Dce	(R^o)	dcE	(r′′)
DCE	(R^*)^o	dCE	(ry)^o

Any two chromosomes, one from each parent, may be inherited by an individual so that 36 different genotypes are possible. The most common of these are shown in Table II.

Fortunately, the majority of these factors are not antigenic and hence cause little or no trouble. The D factor is most antigenic and c and E occasionally cause sensitization. The other factors rarely cause trouble.

Every patient receiving transfusion should be typed for all factors and those that are D negative should receive only Rh negative blood (that is negative for C, D and E). Females of childbearing age or younger who are D or C or E negative should receive only Rh negative blood so that they will not be sensitized and future pregnancy jeopardized.

TABLE II
Common Genotypes

Rh Positive Individuals			Rh Negative Individuals		
DCe/dce	(R_1r)	32.7%	dce/dce	(rr)	15.1%
DCe/DCe	(R_1R_1)	17.7			
DCe/DcE	(R_1R_2)	11.9			
DcE/dce	(R_2r)	11.0	dcE/dce	(r′′r)	0.9
DCe/Dce	(R_1R_o)	2.1			
DcE/DcE	(R_2R_2)	2.0			
Dce/dce	(R or)	2.0			
DCe/dce	(R_1r'')	1.0	dCe/dce	(r′r)	0.8
DCe/dCe	(R_1r)	0.8			

An Rh negative (D negative) female mated to any Rh positive (homozygous) male will give birth to Rh positive (D positive) children in every instance (Table III). If an Rh negative female is mated to a heterozygous male, she will give birth to Rh positive and Rh negative children in approximately equal numbers (Table IV).

TABLE III

DD Homozygous + male		dd Negative female
	Dd Heterozygous + child	

*Presented at a joint meeting of the KSMA's Fourth and Sixth Councilor Districts at Mammoth Cave on June 18, 1959.

Erythroblastosis

When an Rh negative woman carries an Rh positive baby in the uterus, it is thought that some of the baby's red cells escape into the maternal circulation and stimulate the production of anti-Rh antibodies. The antibodies can cross the placenta to enter the fetal circulation and attack the baby's red cells that carry the Rh factor. This causes fetal erythroblastosis. Repeated pregnancy causes greater and greater sensitization of the mother with more and more damage to the Rh positive infants.

In case the husband is a heterozygous male, then approximately one-half the children will be Rh negative and thus unaffected by the antibodies, or the antibody level builds up so slowly that it causes little trouble.

TABLE IV

Dd Heterozygous + Male		dd Negative female
	Dd Heterozygous + child	
	dd Negative child	

Every prenatal patient should be typed for the Rh system. If found to be D negative, her husband should be typed. There is seldom trouble in the first pregnancy, unless the patient has had transfusion prior to the time of typing for the Rh factor. Most of our attention can be focused on the Rh negative multipara whose husband is Rh positive.

In the seventh month of pregnancy these patients should be tested for Rh antibodies. If they show no antibodies at this time, we can be almost sure the baby will be normal. If antibodies are demonstrated, then erythroblastosis should be anticipated and preparations made to do an exchange transfusion on the baby.

Some authorities place great stress on increasing titres or sudden changes in antibody titre, but until more accurate methods are found the presence of antibodies is more important than the level. High-speed centrifuges may prove helpful in demonstrating exactly what antibody is present and information as to what blood type to have available for the baby. More study is needed with these variable speed centrifuges.

Management of Cases

To date nothing has been found that will reduce the sensitization of an Rh negative patient. Our best results come from early induction of labor at 36-37 weeks and then prompt exchange transfusion of the baby.

During labor these patients should have a minimum of sedation and delivered under block anesthesia, if possible. The cord should be left long and not stripped. A sample of cord blood should be sent to the laboratory for immediate examination. A RBC, hemoglobin, Rh, bilirubin and Coombs test should be done.

A positive Coombs test in the baby makes a diagnosis of erythroblastosis. If the RBC or hemoglobin is low, bilirubin increased, or the liver or spleen shows enlargement, then prompt exchange transfusion should be carried out. Rh negative blood compatible with the baby should be used.

After the first 500cc transfusion, the baby's bilirubin should be checked at 8-12 hour intervals. If the level is rising, then additional exchanges should be carried out. The level should be kept below 20 mgms. per cent, and we have found it necessary to do 4-5 exchanges to prevent the bilirubin from approaching this level. Kernicterus and the mental retardation it causes can be prevented by repeated transfusions.

I would now like to give an analysis of 100 consecutive Rh negative patients having a second, third or later pregnancy.

TABLE V

100	Rh negative Multiparae
4	had Rh negative husbands
96	possible sensitizations
18	positive tests for antibodies
11	live babies
8	required exchange transfusions
3	no therapy necessary
7	stillborns

Four husbands were found to be Rh negative. This left 96 women who might possibly be sensitized by pregnancy. Eighteen (18) or 18.7% had positive tests for antibodies.

Eleven live babies were delivered from the 18 sensitized patients. Eight required exchange transfusion. Three babies required no special therapy. Seven babies were stillborn.

TABLE VI

Para	No.	Titre Positive	Baby
2	39	6	4—L
			2—S
3	32	5	4—L
			1—S
4	8	0	8—L
5	14	2	2—S
6	4	4	2—L
			2—S
7	1	1	1—L
9	1	0	1—L
10	1	0	1—L

S—Stillborn L—Living

Table VI shows how the patients were distributed as to parity and the number of living babies and stillborns.

Now to show what can be done in some instances with patients that have had stillborns because of Rh sensitization.

TABLE VII

	Mrs. M. P.
Pregnancies	1—Normal
	2—Stillborn at term
	3—Induction at 37 weeks
	Baby exchanged 2x
	Living & well.

Mrs. M. P. had a normal pregnancy and living child with first pregnancy. During her second pregnancy she had a positive test for Rh antibodies. She was admitted to the hospital a few days before term in spontaneous labor. The fetal heart could not be heard and she delivered an erythroblastotic stillborn. Her third pregnancy was terminated at 37 weeks by induction of labor. The baby weighed 4 pounds 14 ounces and had two exchange transfusions. It is now doing well and appears normal in every way.

TABLE VIII

	Mrs. GWC
Pregnancies 1, 2, 3	—Normal
	4—stillborn at term
	5—stillborn at 39 weeks
	6—Induction at 37 weeks
	Baby exchanged & living
	7—Induction at 37 weeks
	Baby exchanged & living

Mrs. GWC had three normal children. The fourth child was stillborn at term. In the fifth pregnancy an attempt was made to induce labor at 38½ weeks. During this the fetal heart stopped and the patient delivered an erythroblastotic stillborn. In the sixth pregnancy labor was induced at 37 weeks. The baby had two exchange transfusions and survived. A seventh pregnancy was terminated at 37 weeks by induction of labor. The baby was exchanged twice and survived. This patient is one of a very few that have had two stillborns because of erythroblastosis, that later delivered two children that survived because of early induction of labor with prompt and repeated exchange transfusions.

Summary

The management of the Rh negative prenatal patient has been reviewed. Our experiences with 100 consecutive Rh negative multiparae has been summarized. The importance of early and repeated exchange transfusions for the treatment of erythroblastosis in the newborn has been stressed.

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The Golden Scourge*

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Recognition and understanding of an increasingly common medical problem are considered essential to the control of this entity, especially in our hospitals

STAPHYLOCOCCAL disease is not new, only certain aspects of it are. Suppuration, pyema and septicemia were the common sequelae of surgery for centuries. Writing in the March, 1958, Journal of Public Health,[1] Dr. Ravenholt summarizes nicely the recorded history of staph disease, listing medical articles dating back to 1713. He notes that even before Pasteur discovered the key to the disease it was recognized that pustular infections were not an absolute necessity following surgery and that the mortality rate from limb amputation was four times higher in hospital practice than in a private country practice. In 1879, the Pathological Society of London investigated "The Nature and Causes of Those Infective Diseases Known as Pyaemia, Septicemia and Purulent Infection" and demonstrated that these diseases were caused by micrococci and that they usually originated in the hospitals.

The earlier writings showing some recognition and insight in the present problem were mostly in the British and Canadian Journals. As early as 1949 such titles as "Carriage of Penicillin Resistant Staphylococcus Pyogenes in Healthy Adults"[2] and "Incidence of Staph Aureus in the Anterior Nares of Healthy Children"[3] appeared in Lancet and the British Medical Journal. Studies in 1951 were reported in the Journal of Pathology and Bacteriology concerning the "Nasal Carrier Rate of Staph. Pyogenes in Hospital Nurses."[4] However, not until 1956, did articles appear outlining and evaluating experience with increasingly resistant organisms especially in the hospital environment. The studies of Shaffer et al reported in Pediatrics in 1956[5] have been frequently quoted. It required an epidemic in infants resulting in several deaths to focus national attention on the problem.

Mutation and Resistance

Reports in the literature and our personal experience have now been sufficient to allow us to state certain facts and arrive at some conclusions. It is an accepted fact that the staphylococcus aureus organism can mutate fairly readily to develop resistance to common antibiotics when exposed to these under proper circumstances. In fact, it is a little disconcerting to realize that some of these mutated organisms will not reproduce readily in the host unless antibiotics are being administered; that the patient may benefit by stopping the antibiotic.

It is obvious further that we have already lost the battle of developing new, safe, non-toxic antibiotics faster than resistance develops. Consequently, we must evaluate our present position and make the fullest of our advantages.

To date the development of and the foci of resistant organisms has been primarily in hospitalized patients and hospital personnel. Studies on so-called "Street Staph" have not revealed a significant percentage of resistance to commonly used antibiotics. However, the results of an eighteen-month study by the V-A Cooperative Study Committee for Hospital Infections, as reported in April by Dr. Lyndon Lee, Jr.,[6] at the American College of Surgeons

*Presented at a joint meeting of the KSMA's First and Third Councilor Districts at Kentucky Dam Village, Gilbertsville, on May 28, 1959.

sectional meeting in Montreal, revealed that "approximately half of the infected patients studied entered a hospital with the infection already present." He pointed up the findings by posing the question of "how swiftly the reservoir of resistant organisms is building up in the non-hospital community." Continued studies will answer this question.

Severe and sporadic outbreaks of staphylococcal infection have been known for years. This makes it difficult to evaluate the role drug therapy has played in our present episodes and their incidence.

Staphylococcal disease attacks those patients with the lowest resistance. These by nature include especially the newborn infant who has a very low level of serum coagulase, who is readily colonized and serves as a carrier in many instances where no evidence of active disease exists. Other susceptible hosts are the aged and others debilitated or stressed by disease, injury or surgery.

Epidemiology

The manifestations of staphylococcal disease vary with the situation. In many hospitals the newborn nursery serves as a reservoir of resistant organisms. Frequently a healthy carrier may be found among the nursery personnel. The chain of infection here from nursery-to-infant-to-nursing mother can be recognized perhaps most easily. We have found in our experience that the staph organism, once entrenched in the nursery, will colonize as many as 80% of infants by the fourth day of life. We know further that some of these infants may maintain positive nasal cultures as long as four months after discharge without showing overt evidence of staph disease. We have seen the development of resistant pyodermic infections in parents and siblings weeks after leaving the hospital.

The usual nursery epidemic pattern is recognized following the development of several cases of superficial pyoderma or impetigo. Infant or maternal breast abscesses frequently occur, deep abscesses otherwise may occur and especially in premature or otherwise weakened infants septicemia and pneumonia may occur. Drastic measures to stop such an epidemic are required and will be outlined presently.

On the surgical services it has been found that estimates of infection rate have proved in most cases to be low when compared to a survey of all charts. You may be quite astonished if you check all your cases for a period of time and calculate percentages.

On the medical service, as well as surgical service, cultures should be obtained wherever feasible and antibiotic sensitivity patterns obtained. If the culture is unusually resistant, the culture should be sent to the State Board of Health laboratory for phage typing to determine if the organism corresponds to a known epidemic strain.

The clinical picture of overwhelming staph. enteritis is well known, as is the necessity of early recognition and heroic treatment if one is to save these unfortunate patients.

Prevention

Now perhaps some outline of what we can and must do about this problem is in order. If I have one battle cry it is "Back to Lister." Only by the reinstitution of the most rigorous of clean techniques may we hope to control this organism. This problem is recognized by all major medical groups today. The American Hospital Association has issued a set of Recommendations on the Prevention and Control of Staphylococcus Infections in Hospitals.[7] Many other excellent source materials are available to anyone interested in this problem.

Some of this emphasis may seem primary and even "old fashioned," but all of us have become lax in our routines and have depended on antibiotics to control infections. These days are rapidly coming to a close.

Five general approaches to the prevention of spread of infection from patient to patient, from patient to hospital personnel or from hospital personnel to patient have been outlined[8] as follows:

1. Clean and aseptic technique must be used in *all* hospital areas.

2. Recognition of infections in patients and personnel. The hospital admitting officer should be informed of your suspicions of infection and you should conscientiously evaluate risks and aid the hospital in the proper locating of your patient. No treatment should be prescribed to hospital personnel while you are on the run in the halls. If such persons report to you, see

them in your office or such outpatient room assigned and give them adequate examination to determine presence and type of infection.

3. Isolation. All hospitals should have some designated area available for such use, with personnel trained to maintain its integrity.

4. Immunization.

a. Active. Personnel should be protected against smallpox, diphtheria, polio, typhoid, and perhaps influenza.

b. Passive. Gamma globulin may be indicated under certain circumstances such as measles and infectious hepatitis.

5. Drugs and antibiotics. There are certain conditions in which their use is indicated but they should never replace proper technique.

Specific Recommendations

As a pediatrician, and recognizing the nursery as a frequent focus of infection, I will list some specific recommendations for this area.

1. Maintain Nursery Integrity

a. Limit personnel in as much as possible. Enter the nursery only if you have a genuine need to do so. Avoid unnecessary traffic in and out of the unit. Organize the nursery so that supplies needed are within the unit.

b. The regular full-time nursery personnel should use gown technique or clean scrub technique, without masks. All visiting staff, technicians, and others should use cap, mask, gown and usual scrub technique before entering. There should be no showing of any baby at an open window or door without the above routine being practiced.

c. All personnel should wash hands between handling all babies and after handling any contaminated material. Treat the entire nursery as clean and subject to contamination.

d. Isolate suitably any infant suspected of infection.

e. Clear the floor of visitors before taking infants to mothers.

2. Avoid Fomites

a. The common dressing cart or tray on the general floor is a source of continued contamination, as is the central use of items in the nursery. Common alcohol sponge receptacles, Q-tip jars, and vaseline jars as thermometer lubricant are sources of contamination.

b. The use of individual infant technique with all supplies stored under each bassinet is highly recommended.

3. Bathing Routine

a. The use of so-called dry technique of skin care has not aided in the control of infection spread. It is recommended that daily bathing with a soap or preferably a detergent containing 3% hexachlorophene (Phiso-Hex®) be used. We use also the so-called triple dye technique on the umbilical cord without added sponge or band.

On a hospital-wide basis I believe the recommendations of the American Hospital Association should be followed. We all resent directives from above, but these relating to this problem are based on good observation and experience. These include the establishment of a Committee on Infections. Even in a hospital with a small staff the assignment of this responsibility to certain members will enhance effective observation and control of infection. Further, the hospital administration must be aware of the responsibility involved, the care required in all departments including housekeeping to prevent the spread of infection. Personnel policies may have to be established for the handling of personnel who may develop staph disease or prove to be carriers.

Community Education Needed

Lastly, a certain amount of community education must take place. The lay press serves to incite people when some sensational case develops, but patients and families may have to evolve some understanding of restrictions that may need to be placed upon them.

The following measures have been recommended by Dr. Thomas Shaffer[9] when epidemic conditions occur:

1. Identify the organism causing lesions and establish the common identity of strains recovered from a number of lesions.

2. Identify carriers of the pathogenic strain among personnel by culturing all purulent lesions and obtaining nasopharyngeal cultures on all personnel caring for patients.

3. Isolate all infected cases and all patients who are asymptomatic nasal carriers.

4. Appraise hospital practices to detect errors in technique that would encourage dispersion of pathogenic organisms

5. During the time when carriers are being identified it might be necessary to protect infants from the moment of birth by antimicrobial therapy appropriate for the strain causing the epidemic.

6. Open another area for the admission of new patients, staffed with personnel known not to be carriers of the epidemic strain of staphylococci.

As in all medical situations continued awareness and concern are the best defense we have in the control of these situations.

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A Pledge for Kentucky Physicians

I do solemnly swear that I will make every effort to attend the 1960 KSMA Annual Meeting in Louisville on September 20, 21, and 22—and with this pledge, I promise to take immediate action by:

1. *Circling September 20, 21, and 22 on my calendar*
2. *Making arrangements for another physician to handle my practice*
3. *Writing for hotel reservations, if needed*
4. *Notifying patients that I will be out of the office for purpose of adding to my medical "know-how"*

Recognizing that the objective of the Association's Annual Meeting is to contribute to my medical knowledge by providing a varied, interesting and valuable program of postgraduate medical education, I hereby pledge myself to take an active interest in all scientific sessions, exhibits, and in all phases of the program leading to the advancement of the KSMA and the profession of medicine.

Observations Concerning the Treatment Of Chronic Disease

Sidney Roston, M.D.*

Louisville, Ky.

Smooth unfolding of the medical tableaus of the future will depend upon an understanding of the nature of the main drama itself—chronic illness

With ever-increasing control of acute disease, medical attention is shifting to chronic illness. The problems of chronic disease differ considerably from those of acute illness. These differences arise from the slowness of the evolution of long-term disease—evolution which may occupy a significant part of one observer's lifetime. The slow development results in a relative paucity of data and makes difficult unequivocal establishment of chronic disease behavior.

At the present time, the study of chronic disease depends more upon observation of spontaneous occurrence than upon experiment. Of the two methods, experiment is the more potent. Long-term modification of human life, however, raises considerably more serious problems than short-term experimental studies. As a result of these difficulties, embarkation upon an experimental approach to chronic illness in adults must be preceded by particularly careful evaluation of objectives and dangers. Placement of a patient upon a long-term therapeutic regime frequently raises the same problems.

Long and satisfying human life is the goal of medical research and treatment. In a sense, the natural course of human aging, particularly in the older years, is not known. The recent extension of human life has occurred in advanced societies where a highly artificial environment exists, and the human course is modified by many manufactured foodstuffs and other unnatural environmental factors. No human characteristic has as yet been proven to be intrinsically inviolate and unmodifiable. The mere fact that certain characteristics are common does not make them desirable.

Since, for example, increased osteoporosis, hypertension, and coronary artery thrombosis occur after the female menopause, it may be advisable to simulate the pre-menopausal environment by exogenous hormones indefinitely. Perhaps long-term lowering of what is today considered to be average blood pressure may be desirable, or artificial decrease in average heart rate, or periodic reinforcement of normal renal action by use of the artificial kidney, or inhibition of what today is considered to be normal glandular function. The average human characteristic may, in the long run, be as undesirable as what today we consider disease.

Evaluation of Deviations

Treatment of disease, which is a deviation from the average pattern of human life, offers a different problem. Human beings differ from each other in an infinite number of ways. Some of these differences have a relationship to disease and some do not. Determination of which differences have medical significance is frequently difficult. Peripheral blood pressure, for example, varies not only with respect to its systolic and diastolic magnitudes under fixed circumstances, but also with respect to its normal and stress-induced fluctuation, and determination of which pressure elevation represents

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disease and which merely reflects a transient emotional response of no long-term significance frequently requires careful evaluation over a considerable period of time.[1]

From time to time, the range of what is considered normal may change. Between normal and clearly abnormal values is a range of variation which does not have any clear relationship to disease. Evaluation of a long-term therapeutic program involving individuals within this borderline range is particularly difficult, since so much of the variation represents normalcy and not disease.

Cause and Effect

Once the relationship of a deviation to chronic disease is established, the problem of cause and effect arises. A disease may cause change in a biological quantity, the change may cause the disease, or separate factors may independently cause both the change and the disease. The attempt to treat a disease by restoring to normal value a variable whose deviation is the result, and not the cause, of the disease is clearly futile. Yet, for example, decrease in cholesterol has been attempted before any definite cause and effect relationship of cholesterol levels to arteriosclerosis in human beings has been established.[2]

It is true that knowledge of the behavior of a variable may throw light upon a disease, even if not upon the cause and effect relationship. But a considerable amount of caution is necessary before start of a long-term program to correct a deviation which has no proven causal relationship to any human disease.

Pressures on Research

Public demand for new drugs, the need for manufacturing profit, and the desire for recognition in research create strong pressure leading to premature therapeutic use of a drug. This may be defensible when there are no obvious therapeutic dangers. But when dangers exist, the long-range values must be carefully weighed in the light of the risks.

The short-term value of exogenous insulin is so great, for example, that it is widely used, despite lack of knowledge about its relationship to the pathogenesis of arteriosclerosis and other long-term complications of diabetes. A similar urgency does not exist with respect to the oral hypoglycemic agents, both because of their limited value in controlling brittle diabetes and because of the availability of insulin.[3] Since these drugs have been placed into general medical use prior to adequate 10 or 20-year studies, their therapeutic use at this time constitutes a research program, and every person taking these drugs is a participant in this research program.

No one knows at present what long-range effects these drugs will have. The alternative is to wait for completion of a long-term study, and this delay public eagerness to use the drugs will not allow. In the future, when the risks are apparently greater than with the oral hypoglycemic agents, it may be necessary to resist public pressure for many years before general medical use of certain drugs can be permitted, regardless of their effectiveness over the short range.

Additional Problems

Finally, procurement of subjects for long-term studies involves problems additional to those which exist over the short-range. It is obviously more difficult to control an experiment which extends over 20 years than one which lasts a few days. Motivation which is adequate for a few days may be completely inadequate over a 20-year period.

There are few material gains, including money, which will compensate for long-term inconvenience. Even with the best of motivation, continuation of an experiment with unpleasant though not medically-dangerous complications may be difficult for most individuals. A situation of this kind might arise from the loss of certain masculine characteristics during massive therapy with female sex hormone for prophylaxis against coronary artery disease. Supervision over a long range, in the midst of marriage, divorce, economic change, illness and death involving both the participants and the supervisors of the study, may be extremely difficult. In those cases where a drug is clearly necessary to life and health, supervision may be easier than in those cases in which its beneficial effects are not immediately evident. After the start of a long-range experiment, substitution for losses in the original number of participants is extremely difficult.

Principles for Research

Thus, some principles for research in, and therapy of, chronic illness present themselves.

1. The objective of the program must be clear. If the aim is improvement of an average human characteristic, then all individuals with that characteristic are potential candidates for study and treatment. If, however, the objective is restoration of individual deviation toward the norm, then only those persons whose abnormality has a proven relationship to disease should be chosen.

2. The variable under therapeutic study must directly influence, and not have merely a vague relationship to, length of life and individual well-being.

3. The objectives of the study must be compatible with the risks involved. This is particularly true when, because of short-term benefits, a widespread therapeutic program is begun with a new drug before its long-term effects have been properly evaluated.

4. The participants in the study must have strong motivation and must be amenable to adequate supervision.

Summary

The problems of chronic disease differ considerably from those of acute illness. These differences arise from the slowness of the evolution of long-term disease. Experimental study of chronic human disease requires particular clarity of purpose and procedure because of the difficulties involved. The objective may be improvement of an average human characteristic or return of a clinically significant deviation toward the norm. The variable under study must definitely influence health and longevity. The potential results must be compatible with the risks involved and should contribute to strong motivation in the participants.

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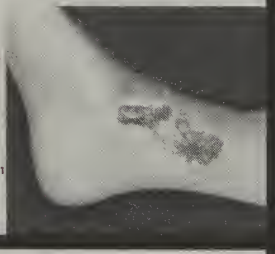


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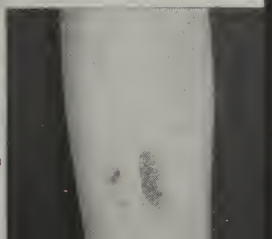


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Brewster Countersink Operation*

D. G. Costigan, M.D.,
James M. Riley, Jr., M.D., *Louisville, Ky.*
Fred E. Coy, Jr., M.D.

The Brewster Countersink operation was designed for a flail post-polio foot. Modification of the technique has improved original operation, authors believe

IN the New England Journal of Medicine[1] of July 13, 1933, Brewster described an operation for countersinking the talus into the os calcis in paralytic feet. There have been objections raised to this surgical procedure on the basis that the operation is technically difficult, displacement of the talus is a frequent complication, and it is unreliable as a means of correcting a dropfoot deformity.[2]

We believe that we have overcome most of these objections by modifying the operation. In the first place, we have restricted the use of the operation to the so-called flail foot, which in most cases results from marked involvement of all the musculature of the leg from poliomyelitis. The only other procedure that can be used in the flail foot in order to replace the continuous use of a brace would be pantalar arthrodesis. This leads to a rather rigid foot.[3]



Figure 1
X-ray of left and right feet. Left foot represents a lateral x-ray view of a Brewster Procedure (note staple); the right foot shows lateral view of triple arthrodesis for comparison purposes.

Modifications

We have modified Brewster's original operation by using a staple on occasions to hold the talus in its countersunk position when the talus fits too loosely in the mortise in the os calcis. (Figure I) We have further modified the operation by stabilizing the talonavicular and calcaneocuboid joints as well as the subtalar joint. This in effect is a triple arthrodesis with the added feature of counterskinking the talus into the os calcis in such a manner that the foot blocks at about ten degrees of dorsiflexion and ten degrees of plantar flexion, a range of motion at the ankle of about twenty

*Presented at the Annual Meeting of the Kentucky State Medical Association in Louisville, Kentucky, in September 1959.

degrees. (Figures 2 and 3) This allows for stability and at the same time enough motion to give a good gait in the flail foot.

Brewster set out to achieve four goals which he lists as: (1) Lateral stability of the foot; (2) limitation of dorsiflexion; (3) limitation of plantar flexion, and (4) a normal looking foot.

Technique

The technique of the operation is as follows: An incision along the lateral aspect of the foot paralleling the subtalar joint and similar to the incision that is made for a triple arthrodesis is employed. The talonavicular, calcaneocuboid and subtalar joints are exposed in the usual manner. The inferior articular surface of the talus and superior articular surface of the os calcis are then removed in a plane parallel to the sole of the foot. An osteotomy cut is now made at right angles through the os calcis, just posterior to the cartilage of the calcaneocuboid joint. The head and neck of the talus are next removed at right angles to the sole of the foot. The foot is then displaced backward to determine at what point the posterior parts of the talus and os calcis are to be removed. The posterior part of the talus is removed at right angles to the sole of the foot. Next the bony prominence on the posterior-superior surface of the os calcis is removed at right angles to the sole of the foot. The wedge of bone in the os calcis is then removed by another cut paralleling the sole of the foot. This provides the countersink in the os calcis into which the talus is now set.

It might be mentioned at this point that two difficulties are encountered: (1) Occasionally soft tissue is interposed, not allowing the countersink to proceed as smoothly as it should, and (2) the talus has a tendency to tilt forward thereby making it difficult to countersink it accurately into the os calcis. In addition to the countersinking of the talus, as described above, the articular surface of the navicular and those



Figure 2
Foot postoperatively blocked at about 90° dorsiflexion.



Figure 3
Foot postoperatively blocking at about 20° plantar flexion.

of the calcaneus and cuboid are denuded in the usual manner so that fusion of these joints as occurs in a triple arthrodesis is carried out.

The after-treatment is exactly the same as in a triple arthrodesis, namely a long leg cast for three to four weeks, followed by a short leg cast for the next eight to ten weeks, part of which time the patient can be weight bearing.

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Acute Disseminated Histoplasmosis

Report of a Case with Observations on the Use of Amphotericin B

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Donald M. Stevens, M.D.

Fort Thomas, Ky.

This disease is common and is being recognized more frequently in this area. Satisfactory treatment, which can be lifesaving, has been developed recently

HISTOPLASMOSIS in the United States appears in greatest concentration in the Ohio and Mississippi River Valleys. In Western Kentucky, there is an especially high incidence of skin reactivity. Kokko et al[1] found a 69% reactor rate to Histoplasmin in the counties of Livingston and Marshall. It was felt that a discussion of a case of disseminated histoplasmosis successfully treated with amphotericin B would be of interest to those practicing in this region.

Case Presentation

C.M., a 59-year-old white male was admitted to St. Luke Hospital of Campbell County, Kentucky, on April 21, 1958, complaining of chills, fever, pain in the chest, a dry non-productive cough and a five-pound weight loss beginning two weeks prior to admission. The patient was born in Wayne County, Kentucky, and had been a soft coal miner and quarry worker, prior to moving to Northern Kentucky where he was employed as a factory worker. In January, 1958, he purchased a small farm and in late February cleaned an old chicken house on his property. He became ill a month or so thereafter.

Past history revealed long standing "indigestion," an occasional low backache and some dysuria. The patient smoked little, but chewed tobacco continually.

Physical examination showed a fairly well nourished man with a temperature of 101°, respirations 16 per minute, and blood pressure 130/80. He did not appear very ill and except for a few coarse rales and rhonchi in the chest, the examination was not remarkable.

The white blood count was 5,600 with a normal differential. Hemoglobin was 14 grams per 100 ml. Urinalysis was normal. Scanty sputum grew coagulase negative staphylococcus aureus and specimens were also cultured for acid fast bacilli and fungi. X-rays showed a normal intravenous pyelogram and degenerative arthritis of the lumbar spine. A chest x-ray on April 21, 1958, showed scattered, rather discrete densities in both lung fields measuring about 8 mm. in diameter (Figure 1). A repeat film, four days later, showed no change.

Treatment consisted of high doses of penicillin, erythromycin, oleandomycin, novobiocin and Furadantin®. Cortisone was given in 50 mg. doses t.i.d. for seven days and an iodine compound was also prescribed.

The patient continued to appear only mildly ill, although occasionally his temperature spiked to 103°. He ate well and when diagnostic studies were complete, he was discharged on April 29 to be followed at home.

He was readmitted on May 19, 1958, because of increasing cough, fever, weakness, malaise, and a 27-pound weight loss. The cough was now productive of moderate amounts of

*From The Department of Medicine, St. Luke Hospital of Campbell County, Kentucky.

thick white sputum always contaminated with chewing tobacco. Physical examination revealed a chronically and acutely ill man, who appeared slightly cyanotic, with a 100° temperature, pulse rate 100, respirations 24, and blood pressure 138/84. Coarse and fine rales were heard throughout both lung fields. Soft pea-sized right supraclavicular and left axillary lymph nodes were felt and the liver and spleen were palpable 3 cm. below the costal margins. Early finger clubbing was noted.

Urinalysis showed a trace of albumin, 2-3 white blood cells per high power field and occasional granular casts. No red cells were seen.



Figure 1

Chest x-ray of June 30, 1958, showing typical lesions. The films did not change appreciably.

The white blood count was 6,700 and remained at this level on subsequent determinations. Hemoglobin was 12 grams/100 ml. on May 19, 1958, but had decreased to 10 grams by June 3, 1958.

PPD first strength skin test was negative on June 3, 1958, and second strength was also negative on June 13, 1958. A histoplasmin skin test was faintly positive and a blastomycosis test was negative on June 3. Sputum cultures for fungi and acid fast bacilli done on the previous admission were reported negative. Papanicolaou smears were also negative for tumor cells. Serum submitted to the Public Health Service Communicable Disease Center, Chamblee, Georgia on May 10, 1958, for complement fixation tests for histoplasmosis (antigens 1 and 2) was negative, although positive for blastomycosis 1:18 and coccidioidomycosis 1:32 dilution.

Biopsy of the right supra-clavicular fat pad on May 24, 1958, was reported as "granulomatous inflammation of lymph nodes" and two days later a needle biopsy of the liver showed "tubercular granuloma of the liver and toxic hepatosis." Tuberculosis and special fungus stains on the biopsy specimens were negative.

Treatment

After multiple blood cultures were obtained, tetracycline 500 mg. q.i.d. was begun and continued for five days with no improvement. Daily temperature spikes continued to 103° or 104°, and the patient was much too ill to eat or even sit up in bed.

On May 27, 1958, amphotericin B therapy was begun. Fifty mg. was dissolved in 1,000 cc of 5% dextrose/water together with 0.5 grams sodium sulfadiazine and given intravenously over a period of 4-6 hours. Prednisone (15 mg. q.i.d. orally) was also begun to reduce the patient's extreme toxicity and to improve his appetite. This dosage was quickly reduced. Daily administration of amphotericin B was continued until July 10, 1958, a total of 43 doses.

Early in treatment an attempt was made to increase the dosage to 100 mg., but severe shaking chills, fever, malaise and anxiety occurred despite the steroids. Antihistaminics and acetyl salicylic acid lessened some of the drug reactions when given before and during the intravenous therapy. Improvement in the patient began in about five days, although the blood urea nitrogen at that time was 43 mg. per cent. Dyspnea became less and cough improved. The spleen receded in size and rales in the chest were less prominent. Prednisone dosage was reduced quickly to 5 mg. daily although it was not discontinued until a few days before amphotericin B was stopped. The temperature decreased to normal after a week of therapy. Blood urea nitrogen was 53 mg. per cent on June 3, but five days later was almost normal. Multiple chest x-rays taken during hospitalization showed little or no change. On lateral

views some slight lessening of infiltrate could be seen, but this was not at all striking.

Pulmonary function studies were done shortly before discharge and were compatible with moderate obstructive emphysema and decreased lung compliance. Complement fixation test repeated on July 8, 1958, showed the yeast phase antigen positive in 1:16 dilution, although culture phase antigen was negative. It was felt that this change in titre confirmed the clinical diagnosis. The patient was discharged on July 12, 1958, complaining only of some weakness and shortness of breath on exertion. He has since regained his former weight and works steadily. Chest x-rays continue to resemble that seen in Figure 1.

Discussion

The clinical syndrome of hepato-splenomegaly, emaciation, irregular pyrexia, leukopenia and anemia, together with disseminated pulmonary infiltrate, is characteristic of this variety of histoplasmosis. Silverman et al[2] have described the disease very adequately and no attempt will be made here to discuss clinical details. The organism was not actually identified in this case, although sputum cultures and gastric washings were not completely satisfactory due to lack of patient cooperation. Blood, lymph node and liver specimens were negative on culture. Unfortunately, the bone marrow was not cultured, but is frequently of value in diagnosis as shown by Lehan et al.[3] However, the typical history, pathogenesis, response to therapy, and rising complement fixation tests make the diagnosis fairly secure. Miliary tuberculosis, lymphogenous spread of carcinoma, lymphoma, and sarcoidosis were all considered early in differential diagnosis and discarded.

The value of steroid therapy in this case is difficult to evaluate. The course given on the first hospitalization seemed to be without effect. When specific therapy was begun, the steroid dosage was quickly decreased to low levels in a few days, and progress continued. The reactions to amphotericin B were apparently not suppressed by Prednisone.

Amphotericin B is an antifungal antibiotic obtained from cultures of a South American strain of Streptomycetacea.[4] A satisfactory preparation first became available for parenteral use in December, 1956[5] and has been of value in the treatment of systemic mycoses including coccidioidomycosis, North American blastomycosis, histoplasmosis, aspergillosis, sporotrichosis chromoblastomycosis and South American blastomycosis.[6]

MRD-112 and other drugs[3,9] have been used also for histoplasmosis, but recently have been discarded as valueless. Amphotericin B is poorly absorbed from the gastrointestinal tract and is best administered intravenously although it has been used topically, subcutaneously and in many other ways.[7] Toxic manifestations include fever, chills, headache, nausea, vomiting, generalized pain and anxiety. Renal toxicity is evidenced by an elevated blood urea nitrogen. Too rapid infusions may cause grand mal convulsions, and even cardiac standstill. Rarely anaphylactic shock, thrombocytopenia and a drop in hematocrit may occur. Phlebitis often occurs at the site of administration. The patient under discussion exhibited most of the minor toxic reactions due to amphotericin B, but chills and fever were controlled by aspirin, antihistaminics, and varying the rate of infusion.

Amphotericin Dosage

It is recommended[7] that the initial dose of amphotericin B is 0.4 mg./kg./day increased by 0.2 mg./kg. to the full adult dose of 1.0 to 1.5 mg./kg. In this case the dosage could not be increased beyond 50 mg. per day because of toxicity. It was given over a period of 6-8 hours, dissolved in 500-1,000ml. 5% dextrose/water and eventually reactions disappeared. It has been shown that serum levels remain elevated for prolonged periods so administration can be every other day.[3]

Because of our patient's poor clinical state, treatment was continued despite an elevated blood urea nitrogen. Although some increase of blood urea nitrogen can be expected, it is recommended that therapy be discontinued or dosage lowered if this occurs. In such an instance, amphotericin B could be administered less frequently or at a lower dosage, gradually increasing over a period of time. Presently, it is felt that the total dosage should be from 2.5 to 3.5 grams. This is an arbitrary figure and will depend on many factors including the patient's receptivity and clinical response.[10]

Phlebitis can be controlled by utilizing the distal veins first and employing a small gauge

needle. An indwelling catheter in the femoral vein can be successful if serious vein problems arise.[6]

Amphotericin B is highly insoluble in aqueous solution and early intravenous preparations were crude suspensions. Newer preparations, however, are more soluble although they are a colloidal suspension with a particle size estimated to be 3 microns.[3,5] Baum et al,[8] have shown that sodium sulfadiazine added to the intravenous solution makes the preparation less turbid. This may represent either an increased amount of amphotericin B in solution or a finer dispersal of the drug. In hamsters with experimental infection the combination of drugs had a better effect then amphotericin B alone. Sodium sulfadiazine singly had no effect on the disease in the hamster.

Despite a rather intensive workup, diagnosis in this patient was made only by serologic methods. The progress of the disease was very rapid so that empirical treatment became necessary. In this endemic area similar clinical and laboratory findings are sufficient to suggest this diagnosis and treatment.

Summary

A case of acute disseminated histoplasmosis successfully treated with amphotericin B is described.

The diagnosis was made by rising complement fixation titre. The organism was not identified by culture or biopsy.

The use of amphotericin B is discussed.

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Plan to Attend

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Motivation, A Major Issue In Management In Rehabilitation*

A 19-year-old white female was admitted to the Neurosurgical service on 9-25-59 immediately following an automobile accident. On admission she was fully conscious and had complete quadriplegia and analgesia below the level of C-7. X-rays of the cervical spine failed to reveal any fractures or dislocations. Lumbar puncture revealed normal manometrics and clear cerebro-spinal fluid. The patient was immediately put on a 5-pound halter neck traction and a Foley catheter anchored.

On 9-26-59 a laminectomy was performed over C-5, C-6, and C-7. Abnormal mobility of the seventh cervical vertebra was noted, suggesting fractures in the pedicles of this vertebra. The dura was incised bilaterally to relieve considerable tension in the cord, which appeared edematous and slightly contused at the C-5 level. A tracheostomy tube was inserted on 9-28-59 as the patient experienced difficulty in expectorating secretions. Her pulmonary vital capacity was 720 cc at this time. On 10-5-59 the patient was put on a Stryker frame with neck traction.

A cystometrogram on 10-13-59 showed good sensory function and fairly normal pressure volume relationship. Her Foley catheter was then clamped for one hour every two hours. Limited physical therapy, consisting mainly of reeducation and passive stretching exercises, was started on 10-7-59 and the patient showed gradual return of motor and sensory function in all extremities, more marked in the lower. The tracheostomy tube was removed on 10-15-59.

The patient was transferred to the Rehabilitation Ward on 10-27-59 and put on the Circulo-matic bed; neck traction was discontinued, and a Dupuy type of neck brace fitted. A more intensive program of physical therapy with progressive ambulation was started and complemented by other rehabilitative disciplines, including occupational therapy, bowel and bladder training, training in activities of daily living, and social counseling. A satisfactory bowel habit was established with the use of dioctyl sodium sulfosuccinate.

The bladder training program met with severe emotional maladjustment and, despite repeated trials for over two months, the patient was completely unable to micturate either voluntarily or involuntarily, except for slight initial dribbling. Finally, with the help of oral neostigmine, good but irregular voidings were obtained and it took another three weeks for the patient to acquire full bladder control, with a residual urine volume of less than 30 cc's.

She made steady progress in her physical restoration and became able to walk without mechanical aid, with slight unsteadiness due to adductor spasticity. A muscle reevaluation showed strength to be fair to good in the lower extremities, with hamstrings and hip adductors being the weakest, and poor to fair in the upper extremities. Spasticity remained marked in the right upper extremity. Her pulmonary vital capacity increased to 1500 cc's. She could manage most activities of daily living with minimal

*Case presented by Xuan T. Truong, M.D., Resident in Physical Medicine and Rehabilitation.

assistance. X-rays of the cervical spine on 12-11-59 showed good bony alignment except for a slight kyphosis at C-4. Her neck brace was removed on 1-25-60.

After the patient had shown good socio-psychological adjustment, she was discharged home on 1-29-60, to continue on physical and occupational therapy as an out-patient.

Discussion

Luis Spamer, M.D., Department of Physical Medicine and Rehabilitation

The case presented illustrates some specific problems encountered in the practice of rehabilitation. The surgeon uses specific surgical techniques and the internist uses specific drugs or other agents in the management of each case respectively. The physiatrist or rehabilitation specialist uses the motivational forces as a tool in a rehabilitation program in the same way.

Sir Rudolph Peters[1] in a recent symposium on the Physiology of Voluntary Muscles stated that, "Brains without muscles would not get animals very far, or the human body out of an armchair. The capacity to move is a dominant fact in biology." We can reverse the statement and say that muscles without brains would have the same effect, emphasizing the indivisibility of their functions. Therefore, since neuromuscular reeducation is an integral part in a rehabilitation program, we cannot neglect motivation as a major tool in the management of a physical disability. In the past and many times at present, this is used intuitively.

As pointed out by Karl A. Menninger[2], "Sometimes these common-sense methods work; many times they don't. The problem of motivation is an extremely complicated one, which, in its technical aspects, constitutes the psychiatric approach to rehabilitation." A rehabilitation specialist is faced continuously with some of these problems and there are a few technical general principles that he should recognize and use accordingly.

Our patient illustrates some of these difficulties. The signs of excessive fear, apprehension, some regression to a childish behavior and increased dependency were observed shortly after the patient's admission to the rehabilitation ward. This became apparent when the patient was ready to assume the erect position. She experienced excessive subjective symptoms of hypotension, such as dizziness, nausea and apprehension, even though her systolic pressure was above 110 mm of Hg. The needed reassurance was provided to the patient by confronting her with the objective readings of a sphygmomanometer and the psychogenic factors in her symptoms were explained to her. She was then more able to tolerate subjectively systolic pressures as low as 80 mm Hg.

There were many difficulties encountered in bladder training and the psychogenic part played became evident. Attempts to make her catheter-free were made early in her rehabilitation program but were unsuccessful. Late in her program she suddenly initiated voluntary urination, but she began to laugh and micturation stopped and the catheter had to be reinserted. "Nearly everyone is familiar with a person who cannot urinate or defecate in the presence of others."[3] Alexander and his collegues[4] attribute this to a reaction against the obligation to give.

We will not enter into a discussion of her psychodynamics but further evidence of this patient's psychosomatic disturbances became more apparent when she developed a brief episode of conversion hysteria, being unable to talk due to an apparent family conflict.

It can be understood why this patient's rehabilitation program was delayed and it is important to remember that most patients who become suddenly disabled need, to a lesser or greater extent, some gratification of their dependency needs in the crucial period of emotional turmoil, as they become aware of the nature of their disability. Sympathetic acceptance through this difficult period of their childish behavior and reassurance of the rehabilitation specialist's support are essential. Under these circumstances it would have been a grave mistake to withdraw support.

At the present the patient is showing an acceptable adjustment to the severe and sudden disablement, but this will not be persistent until she has modified her body-image fully and has accepted wholeheartedly her permanent disability. This will naturally take a prolonged time of months or years during which time she will need to be given continued support.

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SPECIAL ARTICLES

Quo Vadis*

Ira C. Layton, M.D.†

BEFORE one pinpoints the ultimate destination of the medical profession, it seems to me it would be well to review the routes which have been previously traveled. Certainly, along this road, the markers have been quite clear to all except those too occupied to observe and those who were so fearful that they covered their eyes in hopes that the signs would be changed when next they looked.

Out of the depth of this country's most profound depression, many economic changes arose. Social security legislation was proposed and enacted at this time. It became apparent to all that some means of protection against the costs of illness was essential to the population. Blue Cross was the answer.

From the physician's standpoint, some of you will recall instances in which medical attention was not obtained because of the patient's inability to pay and his reluctance to accept service he could not afford. You will also recall quite well instances in which physicians were forced to turn to other occupations in order to augment their greatly diminished incomes. To the credit of the American Medical Association, efforts were made to obtain from commercial insurance companies, assistance in prepayment of medical care through insurance means. The commercial companies, at this time, refused the job on any scale as broad as that proposed.

In Washington, the need for medical care, by large segments of the population, was quite apparent. The new, federal paternalistic philosophy was gaining momentum and finally the threat of Messrs. Wagner, Murray and Dingle rallied support of virtually all physicians behind those who proposed the development of programs which subsequently became Blue Shield.

Expectations Exceeded

Throughout the country, far-sighted and energetic physicians established these plans. They were begun in the interest of both the public and the profession. As a result of their development and to the advantage of both parties, socialized medicine was in large part avoided. The many hours of thought spent by concerned physicians in the early stages of planning led to cautious beginnings while knowledge was developed concerning the relationship of premiums to utilization. Initial programs were quite limited in their scope. Nonetheless, public acceptance was instantaneous and far exceeded all expectations. As success became obvious, the scope of benefits of these plans was broadened and always the same enthusiastic public response resulted.

In recent years, the greatest compliment has been paid to the achievements of Blue Cross and Blue Shield. The commercial insurance companies, who originally rejected the program as ill advised, have entered the field in a highly competitive manner.

Four Philosophic Principles

Inasmuch as these plans developed locally and independently of each other, there were inevitably variations, primarily of a fiscal nature. Differences in fee schedules, full pay-

*Address delivered at the KSMA's 10th Annual County Society Officers Conference at Bowling Green, Kentucky, on March 31, 1960.

†Internist of Kansas City, Mo.; board member and vice-president of the Kansas City Blue Shield Plan. Doctor Layton substituted on the program for F. L. Feierabend, M.D., also of Kansas City, Mo., who was prevented from attending the conference by illness.

ment versus indemnity and scope of benefits, to mention a few. Four major philosophic principles, however, were common to all. These, I would list as follows:

(1) Each Blue Shield program was developed in the public interest in order to make available to all of the public within the limits of reasonable insurance principles and at a common community rate, a means of prepayment of a major part of medical care.

(2) Each program was representative of the profession in the locality it served.

(3) Each was dedicated to the principle that the patient—doctor relationship should not be disturbed by its existence.

(4) Each program attempted to limit its efforts to the economic aspects of medicine and to avoid influence in the normal practice of medicine.

Public Interest at Heart

Certainly Blue Shield programs everywhere were originally established with the public interest at heart. The non-profit nature of these organizations bears witness to the fact. The vast majority of Blue Shield plans include on their governing boards individuals who are there to represent the public. Originally, fee schedules were devised, whether on a full payment or indemnity basis, at levels that would provide reasonable payment to a majority of physicians for much of the population. Broad coverage of members of the community, acceptance of all reasonable risks, provisions for group conversion and the development of individual enrollment programs have all been evidence of the profession's intentions to provide the best possible service for the subscriber.

The success of these programs as a stop-gap against socialized medicine was so great that little effort was made to keep pace with changing times. The threat of federally controlled medicine seemed to have been averted. Reemployment of millions and an expanding economy eliminated the profession's need financially for such programs. Both individual physicians and seemingly organized medicine lost interest in Blue Shield once the immediate crisis was past.

Through the years, fee schedules became inadequate to meet the needs of the public. This led to criticism from both the public and the profession and, in many geographic areas, efforts are under way to correct this inequity.

Competition Brings Change

In recent years, the development of competition from commercial companies has changed the relationship between Blue Shield and the public it serves. Health and welfare issues have now been admitted to the bargaining tables as proper fringe benefits. Too often the result is largely a matter of dollars and cents and not a matter of service required or provided.

When commercial insurance carriers are used, frequently the pennies provided purchase a fairly good surgical schedule, but few benefits are provided for medical illness. Such programs are in contrast to most Blue Shield contracts which provide benefits for both medical and surgical care. Unfortunately such a limited fee schedule can be sold at an attractive price. The availability of these programs has had an adverse effect on the growth of Blue Shield in recent years.

Commercial competition has produced other problems. It has always been the intent of Blue Shield to cover as much of the community as is feasible. Such coverage must include poor risk individuals such as the aged. In years past, the community rate of Blue Shield took care of good and poor risks alike. Now we find that Blue Shield not infrequently loses desirable good risk group contracts even on a non-profit basis to commercial companies who can write for that particular group alone at a lower rate and show a significant profit. Continued loss of such groups will price Blue Shield out of the market for those who need it most and whom the commercial companies will not cover.

Effective Defense

The relationship between Blue Shield and its medical sponsors initially was quite good. Blue Shield provided income for services where income otherwise might not be available. Blue Shield proved to be a most effective defense against the inroads of agencies who wished to insert themselves into the practice of medicine.

Unfortunately, many factors have tended to discourage this excellent relationship with the passage of time. Prosperity has led to less concern on the part of the physician as to whether or not his patient will be able to pay a reasonable fee. Practices have swollen with patients who are well acquainted with wonder drugs, the ravages of cancer and the dangers of heart disease. The resultant affluence has led many physicians to believe that Blue Shield is no

longer an economic necessity and interest in the programs in many areas has waned.

The unexpected success of Blue Shield plans made it difficult for administrative staffs and governing boards to keep physicians informed of their problems, and decisions have, of necessity, been made without soliciting the opinion of the profession in general. A gradual parting of the ways has occurred between busy doctors with little time for Blue Shield and a busy Blue Shield personnel with little time for professional relations. In recent years, physicians have begun to look upon Blue Shield as "just another insurance company," and to wonder why the profession is engaged in insurance practices.

Blue Shield fee schedules have failed to keep pace with mounting overhead, cost of living and increases in average medical fees. Often the Blue Shield subscriber who felt that he had purchased protection sponsored by his physician found in his mail a supplemental bill and was understandably irritated. Criticism was directed toward the physician and the physician in turn reflected it upon the inadequate payment of Blue Shield. On occasion, both subscriber and physician have found payment by a commercial company to be more adequate.

New Generation of Physicians

Sufficient time has passed that a new generation of physicians has arisen. Many of these men are unfamiliar with the background of Blue Shield and unversed in Blue Shield philosophies. As a consequence they have been highly critical of Blue Shield philosophies. As a consequence they have been highly critical of Blue Shield programs. Through lack of information, they look upon these programs as interfering agencies in their practices.

Blue Shield was created to represent the profession in economic affairs with the public. In some respects, Blue Shield has not kept faith with that particular trust.

It was not intended initially that Blue Shield should interfere in patient—doctor relationships. Blue Shield was intended to serve as a depository for funds to be disbursed to the physician for services rendered. Unfortunately, the existence of such funds in the form of Blue Shield inevitably altered the patient's attitude toward the expense of medical care and must have had a similar influence upon the physician. Pressures have been brought to bear to provide services under circumstances which will "utilize insurance" and spare the individual out of pocket expense. This inevitably affects the economic aspects of the patient—doctor relationship and in turn has some bearing on the manner in which medical care is provided.

Although not the intent, this is a by-product of Blue Shield or any program which undertakes to provide benefits earmarked for a specific purpose. Demands for unnecessary services, requests for unnecessary hospitalization and insistence upon the utilization of unnecessary techniques by either patient or physician produced stresses which wear thin the professional relationships and directly affect rate structures of both Blue Shield and Blue Cross.

Economic Aspect Affected

We must recognize that the existence of these programs, or of commercial insurance as well, does have an effect on the economic aspect of the patient—doctor relationship. The existence of such funds makes elective surgery more readily elected. The existence or nonexistence of surgical assistance fees will affect operating room personnel. The presence or absence of allowances for consultation will influence the frequency of consultation. Even the duration of hospital stay will be influenced to some extent by the existence of funds to pay for additional days. In some instances, these allowances will provide for normal adequate care where the absence of such funds might mean substandard treatment. On the other hand, the existence of such funds also invites abuses. The inclusion or exclusion thoughtlessly of certain benefits will influence, to some degree, the manner in which medicine is practiced in a given area and may, in turn, tend to lead the practice of medicine along pathways somewhat different from those which it might have followed.

Effects such as these, I am sure, were unforeseen by the founders of Blue Cross and Blue Shield. Unfortunately, they are present and must be anticipated in our future planning as well as assessed in our evaluation of present and past problems.

Become Public Trusts

Throughout these foregoing comments, I have attempted to point out the routes over which the medical profession has traveled in recent years via Blue Shield. The creation of

Blue Shield has been, I believe, the only truly significant effort on the part of organized medicine to contribute to the public's medical economic problems. It has met with such tremendous success that Blue Shield and Blue Cross have now become virtually public trusts.

I would remind you that Blue Shield was never intended to serve solely for the doctor's benefit at the public expense. If this were true, socialized medicine would have been here long ago. Unfortunately, it would appear that this creation of organized medicine has been sadly neglected since its inception except in times of need. With every threat of offensive federal medical legislation, we have pointed with pride to Blue Cross and Blue Shield as our answer to public demands. Once the crisis was passed, recognition of the programs as part of the medical profession has frequently been withdrawn.

These are the routes we have traveled. A crossroads is at hand. The past two years have seen intensification of the activities of those who would utilize socialized medicine to obtain their own selfish ends. Although it appears unlikely that the Forand Bill will pass in its present form, some sort of Social Security-financed health care may well be enacted by this Congress. It matters not that such action is probably unnecessary, or that it is ill-advised from the standpoint of public welfare, or that it will provide a burdensome economic load upon the population. It is basically an appealing program in an election year. Facts speak not as loudly as votes.

The Only Alternative

We, of the medical profession, can offer only one alternative: Blue Cross and Blue Shield. No one can doubt that prepaid medical care is here to stay. It will remain on a voluntary basis if we can solve our problems, it will be here on an involuntary basis, if we cannot.

The leaders of management, labor and civic organizations must be shown that Blue Shield was provided by the medical profession for the public welfare and that, as such, it is not in itself a member of the insurance industry. They must be convinced that only through Blue Shield and the medical profession can the problems of medical care for the aged, the indigent and other poor risk groups be adequately met, except by the extravagant intervention of the Federal Government.

You members of the profession must recognize that the alternative to cooperative effort through Blue Shield will inevitably be a system of government control in medical care. The commercial companies are totally unwilling to provide adequate programs for poor risk groups. This is unprofitable. Only through Blue Shield can this need be met and only through Blue Shield can the community be served as a whole at a rate which all of the community can afford. We must not, through increased utilization and outright abuse, force premiums of Blue Shield and Blue Cross to levels which those who need it most cannot afford.

Mutually Dependent

Certainly the requests of the public for increased scope of benefits, more adequate fee schedules whether on a service or indemnity basis, will be met and must be met by the doctor's plan if the practice of medicine is to survive in its present form. Blue Shield is an integral part of the practice of medicine. As such, it cannot exist without the support of the medical profession in the area in which it serves. Similarly, the independent practice of medicine cannot long exist in the absence of Blue Shield. We are, in truth, mutually dependent.

Many of the profession have forgotten and others have never learned the "principle of subsidiarity" which may be summed up as follows: "When there is a social problem the solution to that problem must be provided by the lower and better qualified group. If this group either cannot or will not meet its obligation, it becomes the responsibility of the state to do so." Blue Shield is the instrument of the lower and better qualified group, namely the medical profession.

Medical Profession Must Lead

You, as individual members of the profession, must remember the integrity of purpose of Blue Shield. We must not, through our own individual selfish interest, forget that Blue Shield represents the entire profession. Blue Shield must not be led by the efforts of organized minorities into actions which are favorable only to these minorities.

As changes come to this country, medicine

must not always be found fighting a delaying action, especially in view of its relationship to the public which is perhaps at one of the lowest points in recent history. Whatever course the nation takes in its social, political and economic evolution, the medical profession for its own salvation must lead in the development of constructive plans for the delivery of medical service under the new order whatever it may be.

Blue Shield is the plan that has been developed and offered by the profession itself, often identified as the "doctor's plan." Regardless of whether it was started for the benefit only of low income groups and, incidentally, of doctors who must provide them with service, it has undergone a changing pattern like everything else under the firmament. Blue Shield is the only means through which the doctor can keep an intelligent, constructive control over his hire and the conditions under which his care is provided.

The practice of medicine is still in its fundamental aspects a service as dedicated as the ministry and those who base their success on income are not truly in that service. I am sure that in years to come new and better plans for meeting public needs and demands will be found. Such plans are not currently at hand.

Boston Physician Quoted

I do not know Charles H. Bradford, M.D., of Boston, Mass., but in the April 3, 1958, issue of the New England Journal of Medicine, his letter to the editor is published. I should like to quote it in part:

"There need be no ambiguity in defining the present position of the medical profession. It can be summarized in a single word: untenable. Such an assertion hardly invites argument. The experience of practically every other nation in the world corroborates it. Where else do we see the private practice of medicine continuing?

"On one side, we find ourselves threatened by state and federal programs already operating on a large scale and eagerly seeking still further enlargement. On the other side, we contemplate the ugly possibility of domination by pressure groups such as labor unions or dictation from commercial interests such as insurance companies, to mention only two out of many contenders. In front of us we face the inescapable and insurmountable wall of rising costs, in which doctors' fees play only an insignificant part as compared to the staggering costs of hospitalization. Behind us we hear the hue and cry of an increasingly hostile public opinion, unleashed and led on by demagogues who clamor for the priceless gifts of life and health at bargain rates and at the taxpayers' expense. As we fare forth into this dark and uncertain forest of 'social progress,' we can expect about as much security as Little Red Riding Hood enjoyed when she went to visit Grandma!

"One of the few constructive, forward steps taken by the medical profession in the last twenty years has been the adoption of Blue Shield. It may represent one of our few hopes for survival as a self-determining profession.

"If we continue to administer Blue Shield wisely, it may be all that we need to retain our professional independence. To administer it wisely, we must be willing to give as well as to receive—to regulate our practice and our fees so as to preserve our freedom from being regulated and to grant the public as many benefits as we hope to assure for ourselves. But if selfishly administered, Blue Shield is likely to collapse like the house built on sand, for when the rains of public disfavor fall, selfishness will not stand. It lacks the one principle that is essential to all modern institutions: public service.

"We, as doctors, are the managers of Blue Shield. Its success depends on us. Its failures remain our responsibility.

"Is there a moral? Very frankly, yes! We must stop focusing our thoughts childishly on income levels and fee schedules; we must stop bickering and yammering. We must grasp the larger significance of the splendid organization that we have built up in the last twenty years. We must stand behind it in its major decisions —not for selfish gain, but to share with the public a mutual service and benefit."

Quo Vadis. Whither goest thou. This is up to you. If, through excessive use and abuse, we choose to make Blue Cross and Blue Shield inadequate for those who need it most, the government will provide a solution. The medical profession is frequently criticized for its efforts to maintain the status quo and accused of lack of foresight, thereby placing itself always on the defensive. The medical profession and Blue Shield must adapt themselves to changing times. To quote from Frances Bacon "He that will not apply new remedies must expect new ills."

EDITORIALS

A Note Of Caution

BECAUSE many physicians today are too busy or are not inclined to make house visits, and so many patients, for various reasons—some perhaps to save expenses—find it inconvenient to visit the doctor's office, physicians are being asked with increasing frequency to diagnose, prescribe and treat by telephone. A charge is made for this service by some, while others do not charge.

I shall not discuss the question of whether or not physicians should make house calls, nor whether the professional relationship is or would be affected by the doctor charging for such services. Those are questions for the physician to decide. This paper is limited to the legal aspects involved.

Judge L. R. Curtis, author of this editorial, was general counsel for the Kentucky State Medical Association for more than 25 years before becoming Criminal Court Judge of Jefferson County.

The physician is not legally obligated to accept as patients all who apply, and this is particularly true as respects potential patients who phone for medical advice. Obviously, telephonic advice in such cases is too risky both to the physician and to the person on the other end of the line and should never be given.

As respects regular patients, diagnosis, prescriptions and treatment by telephone involves a practice that varies widely in different localities; nevertheless, at best, such is a makeshift practice and the physician should insist upon a personal examination, unless he has previously examined the patient and the symptoms complained of are easily recognized and established. It is elementary that a physician is not an insurer as to untoward or unforeseeable results, but in diagnosis and treatment he is legally obligated to use ordinary care and skill, which means such care and skill as is ordinarily exercised by physicians of ordinary care and skill in the same or similar communities. Liability attaches if he fails to use such care, either over the telephone or otherwise.

Malpractice suits have frequently followed diagnosis and treatment by telephone. In Kansas, the use of the telephone in prescribing aspirin was a poor element in a suit against an 80-year-old health officer. There is a recorded case in the State of Washington, where the patient complained of abdominal pains. After an office examination, the doctor diagnosed the case as "bacterial colitis," or "bowel infection," and gave a prescription for pills. In response to a telephone call the next morning from the wife to the effect that the pains of her husband were more severe, the physician, over the phone, prescribed an enema of soap and water, with the request that a heat pack be applied to the abdomen. It later developed that the patient had a ruptured appendix. A law suit followed.

As this editorial was supposed to be brief, I will conclude with the statement that diagnosing, prescribing and treating by telephone is, at best, precarious. The omission of a personal examination imposes a severe handicap on the defense in a malpractice case. Therefore, every physician who uses the telephone as a substitute for personal examination or in any other phase of his practice should double his precautions to prevent error.

Judge L. R. Curtis

Hospital Admission And Review Committee

THERE appears little doubt that the formation of Blue Shield and Blue Cross and its rapid nation-wide expansion during the past few years has been the greatest single bulwark against socialization of medicine in the United States. The initiative of our profession in meeting the challenge of present-day medical care has commanded the attention and respect of the general public and legislators in both state and national government. In the present discussion regarding the Forand bill, there has been expressed repeatedly the hope that prepaid medical care, as now furnished by Blue Cross and Blue Shield and by commercial carriers, may be so modified and expanded as to render total government care for the aged unnecessary.

So large an undertaking cannot be developed to its present form without careful and accurate planning. This has been accomplished with remarkably little fanfare and with notably few failures of any local Blue Cross plan. It is a tribute to the managers of these many plans that this has been so.

From the beginning there have been misuses and abuses of both the Blue Shield and Blue Cross plan, mostly unintentional, on the part of the subscribers and the physicians. These abuses, none the less, have increased the cost of the plan to the consumer, and in some instances have threatened to raise the price of coverage beyond the practical reach of the subscribers who most need it. During the past three years, there has been a nation-wide awakening to the importance of these abuses which has led most plans to carefully re-evaluate their structure and to adjust their services to a relatively steady premium price within the reach of the consumer.

With these facts in mind last year at the annual meeting of the Blue Cross Advisory Committee, a resolution was offered the House of Delegates of the Kentucky State Medical Association to establish in each hospital in the state Admission and Review Committees to monitor the use of these services within each hospital. It is felt that by this means the present abuses can be reduced to a minimum, and in the future unwise or extravagant use of hospitalization and services beyond the expectation of the plan can be avoided. This action was approved by the House of Delegates and the committee was instructed to implement this provision.

This month there is being widely distributed the "Guide to the Establishment and Functioning of Medical Staff Admission and Review Committee." This work cannot be successful without the wide acceptance and cooperation of the physicians throughout the state. In Kentucky we have an excellent Blue Cross plan which has functioned smoothly with relative minimum of abuses; with premiums and services that are generally satisfactory to the consumer. It is hoped that this trend will continue. It can do so only with our united and unanimous cooperation.

Sam A. Overstreet, M.D.

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Further, because of its different site and mode of action in the renal tubules, Aldactone has a true, highly valuable synergistic activity when used with a mercurial or thiazide diuretic.

What Physicians May Expect of Aldactone

It is fully expected that Aldactone will change present medical concepts of the therapeutic limitations of managing edema. Many patients living in a greater or lesser state of edematous invalidism can now be edema-free. To others, gravely ill, Aldactone will be life-saving.

When used alone, Aldactone will produce a satisfactory diuresis in about half of those patients whose edema is resistant to conventional diuretic agents.

When Aldactone is used in a comprehensive therapeutic regimen, which includes a mercurial or a thiazide diuretic, a satisfactory diuresis and relief of edema may be expected in approximately 85 per cent of edematous patients *who would not otherwise respond.*

DOSAGE: For most adult patients the optimal dosage of Aldactone, brand of spironolactone, is 100 mg. four times daily. Aldactone should be administered for at least four or five days before appraising the initial response, since the onset of therapeutic effect is gradual when it is used alone. Aldactone manifests accelerated activity with greater response as early as the first and second days when used in combination with a mercurial or thiazide diuretic.

SUPPLIED: Aldactone is supplied as compression-coated yellow tablets of 100 mg.

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ORGANIZATION SECTION

Annual Meeting Sept. 20-22 To Include Surprise

Plans for the 1960 Annual Meeting of the Kentucky State Medical Association, which will be held at the Columbia Auditorium in Louisville, September 20-22, are moving ahead, according to Irvin Abell, Jr., M.D., Louisville, KSMA president.

The Committee on Scientific Assembly and Arrangements is working on a new "first" for state medical associations and expects to announce particulars in the June issue of this publication. This innovation should make an important contribution to our Annual Meeting, Doctor Abell said.

Reference committees this year will meet Tuesday afternoon, September 20, in the air-conditioned Sunday School Building of First Christian Church, just a few steps from the Columbia Auditorium, Sam A. Overstreet, M.D., Louisville, Speaker of the House of Delegates, has announced. First meeting of the House will be Monday evening, September 19.

Committees on Scientific and Technical Exhibits are ahead of schedule in their preparations for the meeting, Doctor Abell reported.

Essayists Named for 7th District Meet In Frankfort May 19

The scientific program has been completed for the Seventh Councilor District meeting set for 3 p.m. Thursday, May 19, at the Frankfort Country Club. Announcement of the meeting was made in the April issue of the Journal by the district councilor, Wyatt Norvell, M.D., New Castle.

Essayists and their subjects are: "Antibiotics In Office Practice," William A. Blodgett, M.D., Louisville; "Report Of Unusual Case Of Strepococcic Pneumonia," Shelby Hicks, M.D., New Castle; Cardiovascular Syncopy," Morris M. Weiss, M.D., Louisville, and "Recent Advances In Management of Labor," William E. Pugh, M.D., Louisville.

Irvin Abell, Jr., M.D., Louisville, KSMA president, will be the featured speaker and Hugh C. Williams, M.D., Carrollton, president of the district, will preside. The host group will be the Franklin County Medical Society, headed by Joseph Liebman, M.D., Frankfort.

Land Buying For U. L. Unit Started

Land buying for the University of Louisville's proposed medical-dental research building was authorized by city officials of Louisville on March 29. Acquisition of the site—in the block bounded by Walnut, Madison, Floyd and Preston—is being handled by the Louisville urban-renewal office. The land will be sold to the university after the land is purchased and cleared.

The research building will cost an estimated $2,780,000, about half of which will be provided by the Federal Government. U. of L. officials have expressed the hope that the structure will be completed by the fall of 1961.

Nominating, Awards Committees Organize At Conference

James W. Archer, M.D., Paintsville, was elected chairman of the Nominating Committee of KSMA at its organization meeting held at the County Society Officers Conference in Owensboro on March 31, as provided by Chapter 5, Section 5 of the Bylaws.

The Awards Committee also met, with Douglas E. Scott, M.D., Lexington, presiding in the absence of the chairman, William H. Bizot, M.D., Louisville, who was unable to attend.

Serving with Doctor Archer on the Nominating Committee are Wendell V. Lyon, M.D., Ashland; Daniel E. Mahaffey, M.D., Louisville; Gaithel L. Simpson, M.D., Greenville, and Frank Hays Threlkel, M.D., Owensboro.

On the Awards Committee with Doctor Bizot and Doctor Scott are Theodore Davis, M.D., Barbourville; Horace Harrison, M.D., Owensboro, and W. M. Savage, M.D., Maysville.

KSMA members who have suggestions for nominations are invited to send them to the committees.

Fourth, Sixth Districts to Meet At Mammoth Cave June 9

Plans for the annual late-afternoon and dinner sessions of the joint meeting of the Fourth and Sixth Councilor Districts at Mammoth Cave, Thursday, June 9, have been completed.

This announcement was made by Dixie Snider, M.D., Springfield, Councilor for the Fourth District, and John Pepper Glenn, M.D., Russellville. Councilor for the Sixth District. Irvin Abell, M.D., Louisville, KSMA president, will be the featured after-dinner speaker.

Names of speakers, all from Louisville, and their subjects follow: Douglas M. Haynes, M.D., "Abnormal Uterine Bleeding"; William J. Hockaday, M.D., "A Clarification of Tranquilizers"; and Leonard Legiht, M.D., "Some Clinical Aspects of Mitral-stenosis."

The scientific program will get under way at 4 p.m. (Central Standard Time) in the Blue Room of the Hotel.

'Why Live So Long?' Is Topic Of Senior Day Speaker

"Why Live So Long?" is the subject announced by Lester H. Means, Washington, D. C., featured speaker for Senior Day on Monday, May 16. Mr. Means is government relations director of the General Electric Company.

This year's program, honoring the senior medical students at the University of Louisville School of Medicine, is the sixth annual event sponsored by the Kentucky State Medical Association, in cooperation with the Jefferson County Medical Society and the U. of L. School of Medicine.

The complete program was announced in the April issue of the Journal of KSMA.

Dr. Robertson Is Honored By McCracken Society

Robert W. Robertson, M.D., Paducah, 1958-59 president of the Kentucky State Medical Association, was honored by the McCracken County Medical Society at a surprise testimonial ceremony on March 23. Tribute to the physician for many years of service in civic affairs as well as in professional groups was paid by the principal speaker, Thomas S. Waller, Paducah attorney.



Dr. Robertson

Guests of the society for the occasion were three of Doctor Robertson's colleagues in the 1931 graduating class at the University of Louisville School of Medicine—Theodore Rosenberg, M.D., Paducah; Gaithel L. Simpson, M.D., Greenville, and Kenneth L. Barnes, M.D., Princeton.

Doctor Robertson is a past president of the Kentucky Surgical Society and has served on various KSMA committees, including the Committee on Public Information and Service. He is a fellow of the American College of Surgeons and a member of the Southeastern Surgical Congress, the Southern Surgeons Travel Club and the Excelsior Surgical Society.

KAGP Is Well Represented At National Meeting

More than 20 members of the Kentucky Chapter of the American Academy of General Practice attended a meeting of the American Academy in Philadelphia in March, at which Carroll L. Witten, M.D., Louisville, was elevated to speaker of the congress of delegates.

Officers representing KAGP were Daryl M. Harvey, M.D., Glasgow, president; John G. Archer, M.D., Prestonsburg, president-elect; Charles G. Bryant, M.D., Louisville, immediate past president, and J. S. Williams, M.D., Nicholasville, executive secretary.

Other Kentucky M.D.'s attending, according to information available, included: George S. Allen, James W. Davis, A. L. Goodman, Norman Glazer, Homer Martin, John Ryan and Arthur J. Shulthise, all of Louisville; James C. Lett, J. L. Walker and Ira F. Wheeler, Middlesboro; Harold R. Johnson, Cumberland; C. A. Morris, Covington; Paul J. Sides, Lancaster; John Wright Ratliff, Lebanon; G. W. Sweeney, Liberty; Leland E. Payton, Lynch; A. J. Stifter, Pikeville; Marion C. Spradlin, Somerset.

Hospital Association to Employ Full-Time Director

The Kentucky Hospital Association, at its annual convention in Louisville in March, made plans to broaden its program. The first step will be the employment of a full-time executive director, starting July 1.

Homer D. Coggins, administrator of Central Baptist Hospital, Lexington, was chosen president-elect of the association to take office in March 1961. Installed as president for the coming year was Malcolm H. Black, administrator of the State Tuberculosis Hospital, Glasgow.

The retiring president, Wade Mountz, administrator of Louisville's Norton Memorial Infirmary, has been active in development of the association's new program.

E. W. Horgen, administrator of King's Daughters Hospital, Ashland, was re-elected treasurer. Mrs. Elizabeth D. Simmerman, Lexington, who has been serving as part-time executive secretary, is leaving to take another post.

'MD USA' Is Title Of Special Report To Be Telecast May 27

Television viewing will be especially interesting for KSMA members on Friday night, May 27—the date set for an NBC-TV telecast of a special documentary on the practice of medicine in widely scattered regions of the United States. The hour-long program will start at 8:30 p.m. (EST).

Entitled "MD USA," the report will depict the work of five American physicians in various geographical areas of the country as they provide for a wide array of patients. Sequences were filmed in Alaska, Arizona, Louisiana, Pennsylvania and Wisconsin.

The program, to be telecast in color as well as black and white, is another in the award-winning "March of Medicine" series produced and sponsored by Smith Kline & French Laboratories in cooperation with the American Medical Association.

Dr. Kinsman Elected By ACP

J. Murray Kinsman, M.D., dean of the University of Louisville School of Medicine, was elected first vice-president of the American College of Physicians at a meeting in San Francisco in early April. He has been Kentucky governor for the College.

Doctor Kinsman is president of the Education Council for Foreign Medical Graduates and treasurer of the Association of American Colleges.

1,600 Attend Dental Centennial Convention In Lexington

The Kentucky Dental Association's centennial convention, held in Lexington March 31-April 2, attracted some 1,600 persons. The American Dental Association was represented by the president-elect, four past presidents and nine former trustees.



Dr. Dismukes

The association received an award from ADA and citations from most of the 52 constituent societies of ADA, and from the Kentucky State Medical Association, which was represented by Irvin Abell, Jr., M.D., Louisville, president. Plaques were presented by the state societies of West Virginia, Tennessee, Missouri, Indiana, Ohio and Illinois and by Trustee E. Jeff Justis, Memphis, Tenn.

Dr. J. M. Dismukes, Jr., Paducah, was installed as president of KDA. Named president-elect was Dr. E. J. Buechel, Louisville.

The first record of dental offices in Kentucky was in 1836 when three "barber surgeons" established offices in Lexington. Between the years 1820 and 1829, 13 dentists rode the Louisville, Lexington and Cincinnati circuit. Kentucky's first dental college was established at Transylvania.

Dental Group Makes Dr. Coxwell Full-Time Officer

A. B. Coxwell, D.M.D., secretary of the Kentucky Dental Association since 1948, has become full-time secretary-treasurer of the organization which has its executive offices at 2208 Dundee Road, Louisville.



Dr. Croxwell

A native of Monroeville, Ala., Doctor Coxwell is the son of a physician, Alvin B. Coxwell, M.D., 1907 graduate of the Louisville College of Medicine and long active in the Alabama State Medical Association and Southern Medical Association. He was educated at the University of Alabama and the University of Louisville, where he is now instructor in prosthetic dentistry.

Doctor Coxwell has been a delegate to the American Dental Association since 1948 and is secretary to the ADA State Society Officers. He is an honorary member of the American Society of Oral Surgeons, a fellow of the American College of Dentists and a member of Kappa Alpha, OKU honorary dental fraternity.

Irvin Abell, Jr., M.D., Louisville, president of the Kentucky State Medical Association, congratulated the dental association on this new development. "Our organization looks forward to continuing the high degree of cooperation that has existed between the two associations in the past," he said.

Doctor's Day Observed In State By County Auxiliaries

Doctor's Day, observed nationally on March 30, was marked in Kentucky by the auxiliaries of various county medical societies.

The Boyd-Carter-Greenup group entertained with an open house for physicians and their wives at the home of Edward W. Connelly, M.D., Ashland. The Fulton-Hickman auxiliary was host at a buffet dinner at the Park Terrace in Fulton for physicians of the two counties. The Fayette County women honored their physicians by making a $25 contribution to the YMCA to help pay camping fees for a local girl this summer. On March 31 the members of the Hopkins County Medical Society wore red carnations, presented by the women's auxiliary.

Doctor's Day commemorates the first use of ether in surgery by Crawford W. Long, M.D., of Georgia in 1842.

1960 National Hospital Week Observance May 8-14

The American Medical Association has joined the American Hospital Association in promoting the 1960 observance of National Hospital Week, May 8-14.

Adequate health services for the needy is the goal of a program endorsed by the two associations. A joint committee of the two boards of trustees on November 11, 1959, passed a resolution to mobilize their full resources "to accelerate the development of adequately financed health care programs for needy persons—especially the aged needs—and to stimulate our state and local components to work with local government toward adequate financing of high quality health care for the needy, supported by all available community resources and necessary tax funds."

"The hospital and medical professions have always taken the lead in fulfilling this community responsibility," said a statement issued by the executive vice-presidents of AMA and AHA. "They can again take the lead in improving existing programs and renewing the community's initiative in solving its own problems."

Dr. Edds Named to College Board

W. Gerald Edds, M.D., Calhoun, has been appointed by Governor Combs to the board of regents of Western Kentucky College.

A recipient of the Rural Kentucky Medical Scholarship Fund, Doctor Edds returned to his native McLean county to practice after graduating from the University of Louisville School of Medicine in 1950 and serving his internship. He was one of the leaders in promoting a new hospital now being built in McLean county.



Miami Beach, Florida resort center pictured above, becomes the site of the 109th annual meeting of the American Medical Association on June 13-17. The scientific meeting will take place in the Fontainebleau Hotel and in the air-conditioned Miami Beach Auditorium located a short distance from ocean-front hotels.

2,000 On Program of AMA Meet In Miami Beach June 13-17

Some 2,000 top medical men will participate in presenting the scientific program of the 109th annual meeting of the American Medical Association to be held in Miami Beach, June 13-17. The meeting is the AMA's first in the Florida resort city since the winter of 1954.

Representing the Kentucky State Medical Association at the business sessions will be its delegates to the AMA, W. Vinson Pierce, M.D., Covington, and Robert C. Long, M.D., Louisville; alternate delegates, George P. Archer, M.D., Prestonburg, and J. Vernon Pace, M.D., Paducah, and KSMA president, Irvin Abell, Jr., M.D., Louisville. Advance reports indicate that a number of other KSMA members are planning to attend.

Two general scientific sessions will be held in the Grand Ballroom of the Fontainebleau Hotel. Other lectures, symposiums and panel discussions will take place in the Fontainebleau, Eden Roc Hotel and the new, air-conditioned Miami Beach Exhibition Hall. Sessions on dermatology, being held jointly with the Society for Investigative Dermatology, will be in the di Lido Hotel.

The opening general scientific meeting on Monday afternoon, June 13, will begin with the Joseph Goldberger Lecture on Clinical Nutrition. The second general meeting will be a symposium on "Evaluation and Preparation of Patients for Anesthesia and Surgery," on Tuesday morning, June 14.

The 37th annual convention of the Woman's Auxiliary to the AMA is scheduled to be held in conjunction with the AMA meeting. A safety water demonstration is planned as one of the highlights of the program.

Want to Take a Caribbean Cruise After AMA Meeting?

Physicians planning to attend the annual meeting of the American Medical Association in Miami, June 13-17, may make advance reservations for post-convention tours to the Caribbean, the Dade County Medical Association has announced.

Air and sea cruises to Nassau and Jamaica for three and four days have been arranged for AMA members and their families. Prices start at $54.

A special folder is available by writing to M. John Hanni, Jr., Executive Secretary, Dade County Medical Association, 2 S. E. 13th Street, Miami 32, Fla.

Gifts Will Aid Children

Children will benefit from gifts made to two Louisville institutions last month. The Child Guidance Clinic received a grant of $100,000 from the National Institute of Mental Health for the study of family influences on child behavior, and Children's Hospital was presented $7,000 by the Junior League of Louisville to assure full operation of the hospital's radiology department for a year.

A preliminary study under a $30,000 grant from the National Institute is now nearing completion at the Louisville clinic. Its success led to the larger grant, officials said. The $100,000 will be paid over a period of five years.



Following the morning session of the County Society Officers Conference in Owensboro, the program participants posed for this picture. They were, from left: Ernest B. Howard, M.D., assistant executive vice-president of the American Medical Association, Chicago; Ira C. Layton, M.D., Kansas City, Mo., first vice-president of the board of directors of the Kansas City Blue Shield Plan; Gerald J. Skibbins, research executive of the Opinion Research Corporation, Princeton, N. J., and Irvin Abell, Jr., M.D., Louisville, president of KSMA, who presided.

145 Attend Officers Conference In Owensboro March 31

The 10th Annual County Society Officers Conference attracted 145 when it met in Owensboro on March 31.

The KSMA-sponsored conference, the first held in Owensboro, heard outstanding figures in the fields of medical legislation, prepayment and public relations discuss problems of vital concern to the medical profession.



Congressman Dale Alford, M.D., Little Rock, Ark., was the luncheon speaker.

A plea for physicians to prepare to stand up and be counted on legislative matters was made by Congressman Dale Alford, M.D., Little Rock, in a luncheon address which held his listeners at rapt attention for 45 minutes.

Speaking on "The Legislative Challenge That Medicine Faces," he appealed to his audience to be ready to supply the need and not let politicians have a chance to supply the answer. He urged physicians to take the initiative in providing more reasonably-priced facilities and to work for a more realistic health-insurance program.

"It's high time that doctors get on a first-name basis with the men who represent them in office," the Congressman-physician declared. Medicine's battle will be won or lost at the grass-roots level, he predicted.

The urgent need for action against powerful adversaries of free medicine was emphasized by another speaker, Ernest B. Howard, M.D., Chicago, who described 1960 as the year of the profession's most crucial fight.

Tremendous programs of the opponents are attempting to destroy the image of the American Medical Association, said the AMA executive vice-president. There is no alternative for the AMA but to meet this crisis with an equally well-planned campaign to stem the tide of socialism, he declared.

"We can win the battle if we can continue to fight," Doctor Howard concluded.

Public Held Fair-Minded

A strong and thriving medical profession is what the public wants, the conference was assured by Gerald J. Skibbins, research executive of the Opinion Research Corporation, Princeton, N. J.

When the people understand the alternative in any issue, they always come up with a fair-minded attitude he said. And, in his opinion, they can be relied upon for the right decision once the profession's stand against socialized medicine is clarified for them.

"It's Up to you! The government will provide the answer if we fail!" That was the challenge left with Kentucky physicians by Ira C. Layton, M.D., internist from Kansas City, Mo. Representing Blue Cross-Blue Shield, he substituted on the program for F. A. Feierabend, M.D., also of Kansas City, who was unable to attend the conference because of illness.

Doctor Layton's address is reprinted on Pages 604-608 of this issue of the Journal.

Panel and Reports In Afternoon

The afternoon session of the conference was devoted to a panel discussion moderated by C. Joseph Stetler, Chicago, director of the Law Division of the American Medical Association, and to reports on legislative activity.



One of the popular features at the County Society Officers Conference in Owensboro on March 31 was a panel on legislative matters, moderated by C. Joseph Stetler, center, director of the division of socio-economics and legislative activities of the AMA, Chicago. Other participants were, from left, George Archer, M.D., Prestonsburg, chairman of the KSMA Legislative Committee for National Affairs; Joe Miller, native Kentuckian who is with the division of field services of AMA; Wyatt Norvell, M.D., New Castle, chairman of the KSMA Legislative Committee for State Affairs, and Leon Higdon, M.D., Paducah, KSMA legislative key man for the First Congressional District.



During the legislative panel there were two sets of witnesses. The first were the "unprepared," represented by Carl Cooper, M.D., Bedford, and C. Melvin Bernhard, M.D., Louisville.



The second group of witnesses, the "pros," included KSMA Secretary Woodford B. Troutman, M.D., Louisville, and Ernest B. Howard, M.D., Chicago, assistant executive vice-president of AMA.

Three More M.D.'s Appointed To Commission On Aging

Three Kentucky physicians have been named as additional members of the Citizen's Commission on Aging created by Governor Combs on February 22. The appointment of Ben Hollis, M.D., Louisville; John Quertermous, M.D., Murray, and George Archer, M.D., Prestonsburg, brings to five the number of physicians on the commission. J. Duffy Hancock M.D., and Robertson O. Joplin, M.D., both of Louisville, were on the original list.

Russell E. Teague, M.D., Commissioner of Health, and Harold L. McPheeters, M.D., Commissioner of Mental Health, are members of the Inter-Departmental Committee on Aging, also appointed by the Governor.

The purpose of the Citizen's Commission, as defined by the executive order, is for "the study of the problems of the aged, the initiation of local community interest and action in this field, and the recommendation to the Governor and the General Assembly of measures designed to promote the welfare and betterment of the older people of this Commonwealth."

Another responsibility is to lay the groundwork at the state level for the White House Conference on Aging to be held in Washington, D. C., next January.

Each state receives $15,000 from the Federal Government for this work upon agreement to three provisions: to make a study of problems of the aging in the state, to hold a state conference on aging, and to report its findings to the Federal Government.



KSMA President Irvin Abell, Jr., M.D., Louisville, left, thanks officers of the Daviess County Medical Society, Jack Blackstone, M.D., president, and William Joseph Oldham, M.D., secretary, for their valuable assistance in promoting the successful conference.

Four U. L. Instructors Win Grants Totaling $70,977

Research grants totaling $70,977 to four instructors at the University of Louisville School of Medicine were announced last month.

Robert L. McGeachin, M.D., associate professor of biochemistry, received $42,000 from the National Institutes of Health to continue studies of natural substances in the body known as amylases. The three-year award is effective June 1.

James C. Drye, M.D., professor of surgery, and Eugene H. Conner, M.D., chief of the section of anesthesiology, won a $19,977 grant from the National Heart Institute for a three-year study of injury effects on the lungs.

David C. White, M.D., was granted $9,000 by the American Trudeau Society, the medical branch of the National Tuberculosis Association. Doctor White will use the money to pursue his efforts to isolate viruses from human tuberculosis germs.

AMEF Allocates More Than Million; U. of L. Gets $7,791

Allocation of $1,198,287 to 85 medical schools of the nation was announced in Chicago on April 15 by the American Medical Education Foundation. A grant of $7,791 goes to the University of Louisville School of Medicine.

Contributions, primarily from individual physicians and medical groups, enabled AMEF to make the record distribution. "These contributions, given in addition to countless teaching hours worth thousands of dollars, are impressive evidence of the physician's concern for maintaining high standards of medical education and public health," said George F. Lull, M.D., foundation president.

A total of $9,074,736 has been distributed by the foundation since its creation in 1950. Contributions during 1959, excluding any AMA grants, showed a 17 per cent increase over the previous year.

Dr. Kinsman Explains ECFMG Ruling On Foreign Interns

J. Murray Kinsman, M.D., Louisville, president of the Educational Council for Foreign Medical Graduates, has issued a statement clarifying a new ruling requiring that all foreign medical-school graduates taking approved U. S. internship and residency programs must be certified by the ECFMG. The new plan becomes effective on July 1.

"The Educational Council for Foreign Medical Graduates has now held five examinations at which more than 12,000 individuals have been examined," the dean of the University of Louisville School of Medicine explained. "In a new undertaking of such magnitude and importance as this, every effort must be made to see to it that the new rules cause a minimum of inconvenience and to give to all concerned every opportunity to adjust to the new situation as easily as possible.

"It is important to understand that the ECFMG is only an evaluating agency; its functions are solely to measure the qualifications of foreign medical graduates and to promote educational opportunities for those who are qualified. The authority and the means to make effective any rules or regulations concerning interns and residents in hospitals rest with two of its sponsoring agencies: the American Hospital Association and the American Medical Association, through its Council on Medical Education and Hospitals. Naturally, the steps taken by these organizations to implement the program has the endorsement of ECFMG."

The new policy, announced by the Council on Medical Education and Hospitals, requires that foreign interns and residents must satisfy one of four requirements: (1) they must have a full or unrestricted state license to practice; (2) they must be in their final six months of training; (3) they must have a standard or temporary certificate from ECFMG; or (4) they must have been given a contingent appointment for not more than six months based on acceptance for the September examination.

Hospitals must either cooperate or risk disapproval of training programs, the statement said.

Dr. Bushart Named to U.K. Board

R. W. Bushart, M.D., Fulton, has been appointed by Governor Combs to the board of trustees of the University of Kentucky. He succeeds Wood Hannah, Sr., Prospect.

Doctor Bushart is a former KSMA vice-president and has been active in KSMA committee work. He is the present chairman of the Fulton City Board of Education on which he is serving his eighth year.

Dr. Gaines On Merit-System Unit

Frank M. Gaines, M.D., Louisville, is one of five appointees to a citizens advisory committee on personal administration to help establish a merit system for State workers. The committee, named by Governor Bert Combs, will serve until July when a permanent personnel board is created to supervise the merit-system law enacted by the 1960 General Assembly.

Dr. Jones New TB Board Member

Boyce E. Jones, M.D., London, is one of two new members appointed to the Kentucky Tuberculosis Hospital Commission by Governor Bert Combs. He succeeds V. A. Jackson, M.D., Clinton.

Reappointed to the commission were C. C. Howard, M.D., Glasgow, chairman of the body, and Alec Spencer, M.D., West Liberty.

Dr. Rosenbaum Named to U.K. Post

Harold D. Rosenbaum, M.D., Lexington, has been named chairman of the department of radiology at the University of Kentucky's College of Medicine. Doctor Rosenbaum was certified in radiology in 1952 by the American Board of Radiology.



A total of 105 physicians attended a meeting of the Kentucky Committee on Trauma of the American College of Surgeons, held recently at Fort Campbell. In addition to the Fort Campbell medical staff, members of the Christian County Medical Society and physicians from Clarksville, Tenn., were invited. At the speakers table were, front row, left to right: William T. Rumage, Jr., M.D.; R. Arnold Griswold, M.D.; Robert Lich, Jr., M.D.; F. Albert Olash, M.D., and Ludwig H. Segerberg, M.D., all of Louisville; back row: Preston Higgins, M.D., Hopkinsville, president of the Christian County Medical Society; Major General Westmoreland, Commanding Officer of Fort Campbell; Colonel Kamish, Commanding Officer of the Fort Campbell hospital, and Colonel Van Wagoner of the Surgeon General's office.

Science Writers Seminar Draws Top Cancer Researchers

Eminent research scientists brought the nation's science writers up-to-date on the latest in cancer research at the American Cancer Society's third annual Science Writers Seminar, held March 27-April 1 at the Brown Suburban in Louisville. Forty researchers and about 45 science reporters for newspapers and magazines participated in the five-day "meet the press."

The program consisted of 10 panels covering the following subjects: Chemotherapy, Viruses, Lung Cancer, The Gene and the Cell, Environmental Cancer, Leukemia, Endocrinology, Basic Immunology, Clinical Immunology and Biochemstry. Several hopeful drugs were described by the scientists.

Host for the event was Richard F. Grise, M.D., Bowling Green, president of the Kentucky Division, American Cancer Society. The Kentucky Division has extended an invitation for the 1961 seminar to be held in Louisville.

Industrial Medical Group Holds First Annual Meeting

The Kentucky Industrial Medical Association, a new organization of 41 members, held its first annual meeting in Lexington on April 7. The International Business Machines Corporation was host for the event.

Eugene H. Kremer, M.D., Louisville, was installed as president, succeeding Gradie R. Rowntree, M.D., Louisville, the association's first head. Chosen president-elect was Charles Martin, M.D., Lexington.

Featured speakers at the meeting were four nationally known industrial physicians, including the president of the Industrial Medical Association, D. John Lauer, M.D., Pittsburgh. The other speakers were: Raymond R. Suskind, M.D., Kettering Laboratory, University of Cincinnati College of Medicine; A. A. McLean, M.D., New York, faculty member of Cornell University Medical College, and H. W. Lawrence, M.D., Cincinnati.

The Kentucky association was organized in Louisville on September 11, 1959, and has been accepted as a component society of the Industrial Medical Association. Its purposes are: To foster the study of problems peculiar to the practice of industrial medicine and surgery, to encourage development of methods adapted to the conservation and improvement of health among workers, and to promote more general understanding of the purposes and results of medical care of these workers.

'Loan Bank' For Arthritics Set Up In Louisville

A "loan bank" of self-help devices for arthritics in Kentucky has been established in Louisville by the Kentucky Chapter, Arthritis and Rheumatism Foundation. The bank is located at the Rehabilitation Center, 340 East Madison Street, and is in charge of Rex O. McMorris, M.D., medical director of the Center.

The mechanical aids will be provided to indigent arthritics on a loan basis, if they have written referrals by a physician, clinic or county health department. A referral must state that the patient cannot afford to pay for the needed device.

Further information regarding the bank may be obtained from the Kentucky Chapter, ARF, 211 Speed Building, Louisville.

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(2) The Vehicle
NEO-ARISTODERM Foam spreads readily without irritation or burning. It can be applied to oozing, crusted, severely inflamed and injured skin, or to mucous membranes. There have been no reactions of primary irritation or allergic sensitization to date.

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NEO-ARISTODERM Foam *is neat—not messy or sticky*. Patients like the attractive push-button dispenser and the richness of the foam. This helps to assure faithful adherence to your instructions.

Triamcinolone Acetonide 0.1%, Neomycin Sulfate 0.35% 15 cc. Push-button dispenser

References: 1. Kanof, N. B., and Blau, S.: *New York J. Med.* 59:2184 (June 1) 1959.
2. Smith, J. G., Jr.; Zawisza, R. J., and Blank, H.: *A.M.A. Arch. Dermat.* 78:643 (Nov.) 1958.

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S-413



PG Listing Includes First Program In Series By KSMA's New Education Fund

A "Symposium on Selected Topics on Gastro-Intestinal Diseases," scheduled for May 25 and 26 at the University of Kentucky Medical Center, is the first in a series of postgraduate opportunities under a program initiated by KSMA's new Postgraduate Medical Education Fund.

A feature of the program will be a guided tour through the new Medical Center, which is expected to draw physicians from other states as well as Kentucky.

Postgraduate offerings in Kentucky and adjacent states for the coming three months are listed as follows:

May

11-13 Kentucky Academy of General Practice, annual meeting; Kentucky Hotel, Louisville.

12-14 Kentucky Obstetrical and Gynecological Society, annual meeting; Campbell House, Lexington.

17 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

18-19 "Postgraduate Course in Diagnosis and Treatment of Common Endocrine Disorders"; Indiana University School of Medicine, Indianapolis; fee, $20.

18-20 "Postgraduate Course in Fractures and Dislocations"; University of Tennessee College of Medicine, Memphis.

19 Meeting of Seventh Councilor District, with scientific presentation; Frankfort County Club; 3 to 5:15 p.m.

25 State Tuberculosis Hospital Chest Group meeting; State Tuberculosis Hospital, District 2, Louisville; 8 p.m.

25-26 "Symposium on Selected Topics on Gastro-Intestinal Diseases"; University of Kentucky, Medical Center, Room MN 263, Medical Science Building, Lexington, 9:15 a.m. Approved for 7 hours category I credit. No fees charged.

25-27 "Postgraduate Course in Psychiatry for the Family Physician"; University of Tennessee College of Medicine, Memphis.

31 Meeting of Second Councilor District, with scientific presentation; Gabe's Restaurant, Owensboro; 6:30 p.m. (CST).

June

9 Joint meeting of the 4th and 6th Councilor Districts, with five scientific-paper presentations for general practitioners; Mammoth Cave Hotel; 3:30 p.m.

14 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

17-18 Kentucky and Indiana Chapters of the American College of Surgeons and the Kentucky Society of Anesthesiologists and corresponding anesthesiology organization of Indiana, joint meeting; French Lick, Ind.

20-24 "Postgraduate Course in Internal Medicine," sponsored by the American College of Physicians; Indiana University School of Medicine, Indianapolis; Medical Science Building, Room B-26. Registration fee: ACP members, $60; non-members, $80.

July

19 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m; State Tuberculosis Hospital, District 2, Louisville.

27-29 "Postgraduate Course in Tumors—Diagnosis and Treatment"; University of Tennessee College of Medicine, Memphis.

August

16 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

Ninth, Eleventh Districts Join In Paris Meeting

KSMA members from 20 counties attended a joint meeting of the Ninth and Eleventh Councilor Districts held April 14 at the Tuberculosis Hospital in Paris. Isadore Zapolsky, M.D., superintendent of the hospital, was host.

The featured address was delivered by the KSMA president, Irvin Abell, Jr., M.D., Louisville, who spoke on "The Political Climate for American Medicine."

Five Louisville physicians were essayists for the scientific program. Subjects presented were: "Psychiatry for the G.P.," Frank M. Gaines, Jr., M.D.; "G. I. Surgery," Samuel D. Weakley, Jr., M.D.; "Open Heart Surgery," Daniel E. Mahaffey, M.D.; "Items In Endocrinology," James R. Hendon, M.D., and "Changing Status Of Pneumonia," Grover B. Sanders, M.D.

Dr. Kamp New KAPHP Head

Maurice Kamp, M.D., director of the Louisville-Jefferson County Health Department, assumed the presidency of the Kentucky Association of Public Health Physicians at its annual meeting held in Louisville in early April. He succeeds Mildred E. Gabbard, M.D., Booneville.

Chosen president-elect of the association was M. A. Shepherd, M.D., Somerset, health officer of Laurel, McCreary and Pulaski counties. Doctor Shepherd served last year as president of the Kentucky Public Health Association.

NEWS ITEMS

Henry H. Dunham, M.D., who formerly practiced in Kansas, has joined the Henderson Clinic, Henderson. His speciality in radiology. A native of Galesburg, Kan., Doctor Dunham received his M.D. degree from Kansas University in 1944. He interned at the University of Wisconsin and was a resident at the University of Kansas for three years. He served as a lieutenant (j. g.) in the Medical Corps, U. S. Naval Reserve, in 1945-46.

L. C. Hafner, M.D., Hebron, was honored at a special ceremony at the open house of the Kenton-Boone Opportunity School and the Northern Kentucky Treatment Center, Levassor, on March 30. Doctor Hafner has been actively identified with crippled-children work for 30 years and helped establish the orthopedic ward for crippled children at St. Elizabeth Hospital, Covington.

P. D. Hitchcock, M.D., after a brief practice as a general practitioner in Upton, has located in Edmonton. Born in New York State in 1931, Doctor Hitchcock was graduated from the University of Louisville School of Medicine in 1958 and interned at St. Elizabeth Hospital, Dayton, Ohio. He served in the U. S. Army in 1951-52 with the rank of sergeant.

Lt. Wayne W. Kotcamp, M.D., has joined the staff of the U. S. Naval Hospital, Quantico, Va., after serving residencies at Norton Memorial Infirmary, General Hospital and Kosair Crippled Children Hospital in Louisville. Lieutenant Kotcamp was graduated from the University of Louisville School of Medicine in 1954.

Francis M. Massie, M.D., Lexington, recently addressed the Pilot Club of that city on the restoration of the Ephraim McDowell shrine in Danville. He illustrated his talk with film slides showing the McDowell home and apothecary before and after restoration. Doctor Massie is chairman of the KSMA McDowell Committee.

Eugene Q. Parr, M.D., a 1952 graduate of the University of Louisville School of Medicine, has been appointed to the staff of the Lexington Clinic in the Section of Orthopedic Surgery. Doctor Parr served his internship at the Baroness-Erlanger Hospital, Chattanooga, Tenn., in 1952-53 and was in general practice in Berea from 1953 to 1956. In 1956 he accepted a fellowship in orthopedic surgery at the Mayo Foundation for Education and Research, and has just concluded the four years there.

Carl Baker Rankin, M.D., has started the practice of medicine in Cadiz in association with Elias Futrell, M.D., and John Futrell, M.D. A native of Monticello, Doctor Rankin received his M.D. degree from the University of Tennessee in 1959 and served his internship at John Gaston Hospital, Memphis.

Frank T. Smith, M.D., a native of Gallatin, Tenn., has opened an office in Middlesboro for the general practice of medicine. Doctor Smith received his medical degree from the University of Tennessee in 1958, interned at Nashville General Hospital and started practice in Jamestown, Tenn. He served three years in the Medical Department of the U. S. Navy.

Alex J. Steigman, M.D., chairman of the department of pediatrics at the University of Louisville School of Medicine, served as chairman of a two-day conference on pediatrics at the University of Miami School, Miami, Fla., April 8 and 9. Also taking part in the parley were three other U. of L. pediatrics faculty members: **William C. Adams, M.D.; Mary Cruise, M.D.,** and **Joseph A. Little, M.D.**

George H. Zwick, M.D., Dayton, president of Speers Memorial Hospital, accepted for the hospital a certificate of recognition by the American Hospital Association. The presentation was made at the annual convention of the Kentucky Hospital Association held in Louisville in March.

700 Attend Public Health Group's Meeting In Louisville

The Kentucky Public Health Association's 12th annual meeting drew more than 700 public-health workers from all parts of the state to Louisville for the three-day session which opened April 5 at the Sheraton Hotel. Theme of the program was "Bridging the Gap."

Miss Ruth Spurrier, director of public-health nursing for the State Department of Health, was installed as president during the meeting. She succeeds M. A. Shepherd, M.D., Somerset, health officer for Laurel, McCreary and Pulaski counties. Named president-elect was Thomas P. Summers, Louisville, executive director of the Kentucky Tuberculosis Association.

Next year, Miss Spurrier announced, the association will participate in a meeting of the Southern Branch of the American Public Health Association scheduled to be held in Louisville in April. The state group will meet in annual session immediately prior to the Southern convention.

Dr. Stevens Wins $10,500 Award

Kingsley M. Stevens, M.D., assistant professor of medicine at the University of Kentucky College of Medicine, has been granted a Lederle Medical Faculty Award of $10,500. The three-year award is aimed at encouraging young doctors to stay in academic medicine.

Doctor Stevens, who joined the U. of K. faculty in 1959, is currently setting up research programs in antibody formation, the relationship of antibodies to kidney disease, and a cancer study. A graduate of Harvard Medical College, he took a special isotope course at Duke University, and has been an Atomic Energy Commission fellow at the University of Chicago and a fellow of the National Institutes of Health at the Hall Institute, Melbourne, Australia.



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M.D.'s Address Meetings

Gaithel L. Simpson, M.D., Greenville, was the principal speaker at a church and social work conference at the Carver School of Missions and Social Work in Louisville on April 13. Doctor Simpson, who is chairman of the KSMA Committee on Education and Economics, discussed the Forand bill.

Physicians addressing the annual convention of the Kentucky Association of Nursing Homes included Russell E. Teague, M.D., State Commissioner of Health; George W. Pedigo, Jr., M.D., Ben H. Hollis, M.D., George F. McAuliffe, M.D., and Louis M. Foltz, M.D., all of Louisville. The meeting was held April 13 and 14 at the Sheraton Hotel, Louisville.

Dr. Asman Gets Cancer Award

Henry B. Asman, M.D., Louisville, received the 1960 divisional award of the Kentucky Division, American Cancer Society, for the most outstanding contribution to its program during the past year. He was awarded a medallion and framed certificate.

Blue Cross-Shield Honor Students

The senior medical students at the University of Louisville School of Medicine were honored by Blue Cross-Blue Shield at a special luncheon on March 25. J. Ed McConnell, assistant director of Blue Cross-Blue Shield, served as toastmaster.

The program included a panel discussion moderated by Hoyt Gardner, M.D. Members of the panel were H. Hart Hagan, M.D.; Sam Overstreet, M.D.; Edward L. Browning, of the Lincoln Income Life Insurance Company, and D. Lane Tynes, executive director of Kentucky Physicians Mutual. The students went on guided tours of the Blue Cross-Blue Shield building before the luncheon.

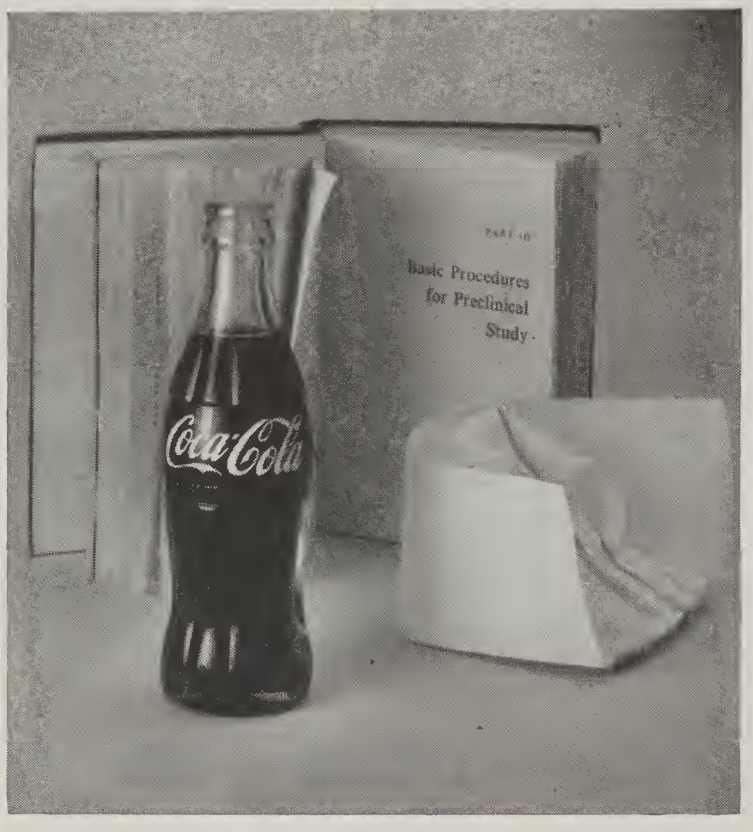
Pediatric Clinic Announced

A Pediatric Cancer Clinic for children up to 16 years of age is held every Tuesday at St. Joseph Infirmary, Louisville, announces Robert M. Hofmann, assistant administrator. All new patients must be referred to the clinic by a private physician, and patients should be in the hospital by 12:30 p.m.

U. L. Host to Premedical Society

About 200 premedical and predental students and educators attended the 13th annual convention of Alpha Epsilon Delta, national premedical honor society, held April 7-9 at the University of Louisville.

The call for more family doctors is one of the challenges today's medical students must face in the future, the society was told by its banquet speaker, Dr. Ward Darley, Evanston, Ill., executive director of the Association of American Medical Colleges. Among the other speakers was William K. Keller, M.D., professor of psychiatry at the U. of L. School of Medicine.



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Student AMA

One of the foremost topics discussed among medical students at the University of Louisville concerns the Forand bill and possible subsequent socialized medical legislation. Although we students have not experienced private practice with free enterprise type of medicine, most of us have rather dogmatic views on the subject.

It seems that the complacency most doctors have had in the past regarding socialized medicine has been jolted heavily in the last year. Although the Forand bill has been killed in the House Ways and Means Committee, the American people have been introduced to a plan which sounds quite attractive when superficially examined. Proposed socialized medicine for the aged promises to be in the political platform in the election this very year. All of us realize that once the foot is in the door, more will eventually follow.

We in medical school do not feel that it is for selfish reasons that physicians are against the socialization of medicine. This country has thrived and become the greatest nation in the world under a free enterprise type of government. The incentive to better oneself is the rule behind our national tradition. We are aware of the fact that every time the government expands, some more of our liberties are taken from us.

The attractiveness of receiving something for nothing appeals to the masses who know not its consequences. The AFL and CIO, the foremost proponent of the Forand bill, has proved its Machiavellian ways; by continually giving or promising more to its members, labor remains in vogue. One wonders how attractive it would seem to Walter Reuther and his peers if the AFL and CIO were controlled by our government.

As we medical students gaze into a dark black crystal ball and see socialized medicine in this country, we are concerned of the results. The cost of such a program has been greatly underestimated. The paper work required for the physician by the government would leave little time for the practice of medicine. The close patient-doctor relationship would be jeopardized; the patient would become an ill number instead of an ill person. The caliber and number of persons desiring entrance to medical school would diminish.

We cannot afford complacency just because the Forand bill has been thrown out. Similar bills will soon appear. Only through our patients can we show that the present way is the best way—for them.

Robert K. McKechnie
President, U. of L. Chapter
Student AMA

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County Society Reports

Harlan County

Sanford Weiler, M.D., and Paul O. Wells, M.D., Harlan, and Walter Stepchuck, M.D., Evarts, were appointed to the W. Clark Bailey Memorial Fund Committee of the Harlan County Medical Society at the group's March meeting. Doctor Weiler was named chairman.

Essayist for the scientific session was Alexander Langmuir, M.D., chief of the Epidemiological Branch of the Communicable Disease Center in Atlanta, Ga. His talk on "Staphylococcal Infections In Hospitals" was followed by a discussion period.

McCracken County

The McCracken County Medical Society honored Robert W. Robertson, M.D., in a surprise testimonial ceremony at its March meeting. Paducah attorney Thomas S. Waller, the principal speaker, said in praise of the physician: "It is my firm belief that Doctor Robertson's great and unselfish giving of himself to needy patients is the real basis of the popularity which has contributed to his material success." After responding to the tribute, Doctor Robertson was given a standing ovation by the society.

(A story about Doctor Robertson's honor is on Page 613 of this issue of the Journal).

At the business session, the society passed a motion providing "that the Constitution and Bylaws be changed to include a Committee on Constitution and Bylaws and a Committee on Public Relations and Legislation. This committee shall consist of six members, three members to be the delegates to the KSMA convention and the other three members to be elected annually. The functions of this committee shall be the duties of the individual committees as defined in the Bylaws of the State and Local Society."

The secretary was instructed to draw up these changes and mail copies to the members before the next monthly meeting.

A motion to accept J. O. Nall, M.D., into the society as an active member was passed unanimously.

Kentucky Practical Nurses Group Elects Mrs. Jenkins

Mrs. Elizabeth Jenkins, Lyndon, was elected president of the Kentucky State Association of Licensed Practical Nurses at its state convention in Lexington, April 8 and 9. She succeeds Mrs. Goldie Waskey, Russell. Mrs. Jenkins, now employed at Central State Hospital, has served her association as area president for several years.

Keynote address for the convention was delivered by Dr. Marcia Dake, dean of the School of Nursing at the University of Kentucky Medical Center. Other speakers included Mrs. Clara A. Roitero, president of the National Association of Licensed Practical Nurses, and Miss Wilkie Hughes, secretary of the National Association of Practical Nurses Education.

Covington was chosen as the meeting place for the 1961 convention.

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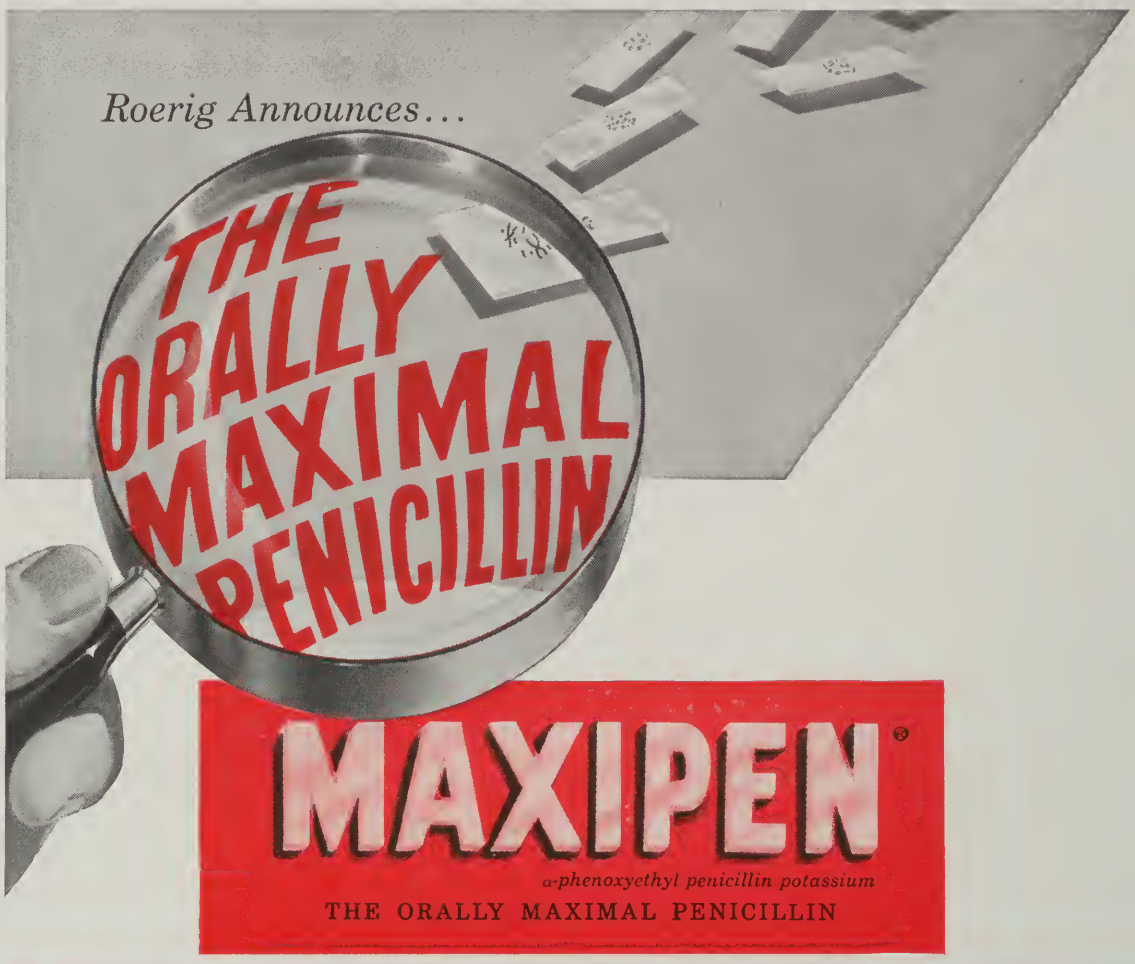
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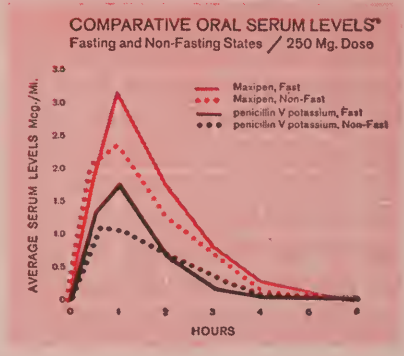
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In Memoriam

M. A. BIZZELL, M.D.
Barbourville
1878 - 1959

Matthew Andrew Bizzell, M.D., who practiced private and industrial medicine in Kentucky, died on April 4, 1959, at Daytona Beach, Fla. He was 81.

Born at Locksburg, Ark., Doctor Bizzell was graduated from the Louisville Medical College in 1903. He was a member in good standing of the Knox County Medical Society and the Kentucky State Medical Association at the time of his retirement in 1950.

W. A. DUNCAN, M.D.
Russellville
1877 - 1960

William A. Duncan, M.D., retired Russellville physician, died on April 3 at the Logan County Hospital at the age of 83 years.

Doctor Duncan was graduated from Vanderbilt University School of Medicine in 1903 and served as a lieutenant colonel during World War I. He retired from active practice after returning to civilian life. While in the Army, he reportedly developed the first field X-ray equipment.

EZRA C. HARNED, M.D.
Louisville
1869 - 1960

Ezra C. Harned, M.D., retired physician, died on March 25 at his home in Louisville at the age of 91.

Doctor Harned practiced medicine in Breckinridge county for 52 years before moving to Louisville in 1942. He was a graduate of the University of Louisville Medical School.

LESLIE LOGAN, M.D.
Barbourville
1880 - 1960

Leslie Logan, M.D., retired physician and surgeon of Barbourville, died on April 1 at St. Joseph Infirmary, Louisville. He was 79.

A 1908 graduate of the Louisville Hospital Medical College, Doctor Logan owned and operated the old Logan Hospital at Barbourville for a number of years. He was an emeritus member of the Kentucky State Medical Association.

J. L. RICHARDSON, M.D.
Ashland
1872 - 1960

James L. Richardson, M.D., a practicing physician for six decades, died on March 23 at King's Daughters Hospital, Ashland. He was 88.

Doctor Richardson was graduated from the Electric Medical College, Cincinnati, in 1899 and practiced in his home town of Lowes for 11 years before going to Ashland in 1910. He delivered more than 5,000 babies during his long practice.

G. W. SMITH, M.D.
Louisville
1865 - 1960

George W. Smith, M.D., retired physician who formerly practiced in Hart county, died in Louisville on April 18. He was 95.

Doctor Smith was graduated from the old Louisville Medical School in 1893. Besides practicing in Hart county, he was company doctor for the Louisville & Nashville Railroad in the Horse Cave area for a number of years.

G. P. WEBB, M.D.
Burning Springs
1877 - 1960

Granville P. Webb, M.D., physician at Burning Springs for more than half a century, died April 7 at Good Samaritan Hospital, Lexington. He was 84.

Doctor Webb located at Burning Springs after receiving his medical degree from the University of Louisville in 1905. His practice covered parts of three counties. Doctor Webb was a member of the Clay County Board of Health for a number of years.

A. A. WEDDLE, M.D.
Somerset
1879 - 1960

A. A. Weddle, M.D., rural physician for 51 years, died April 12 at Somerset General Hospital at the age of 80 years.

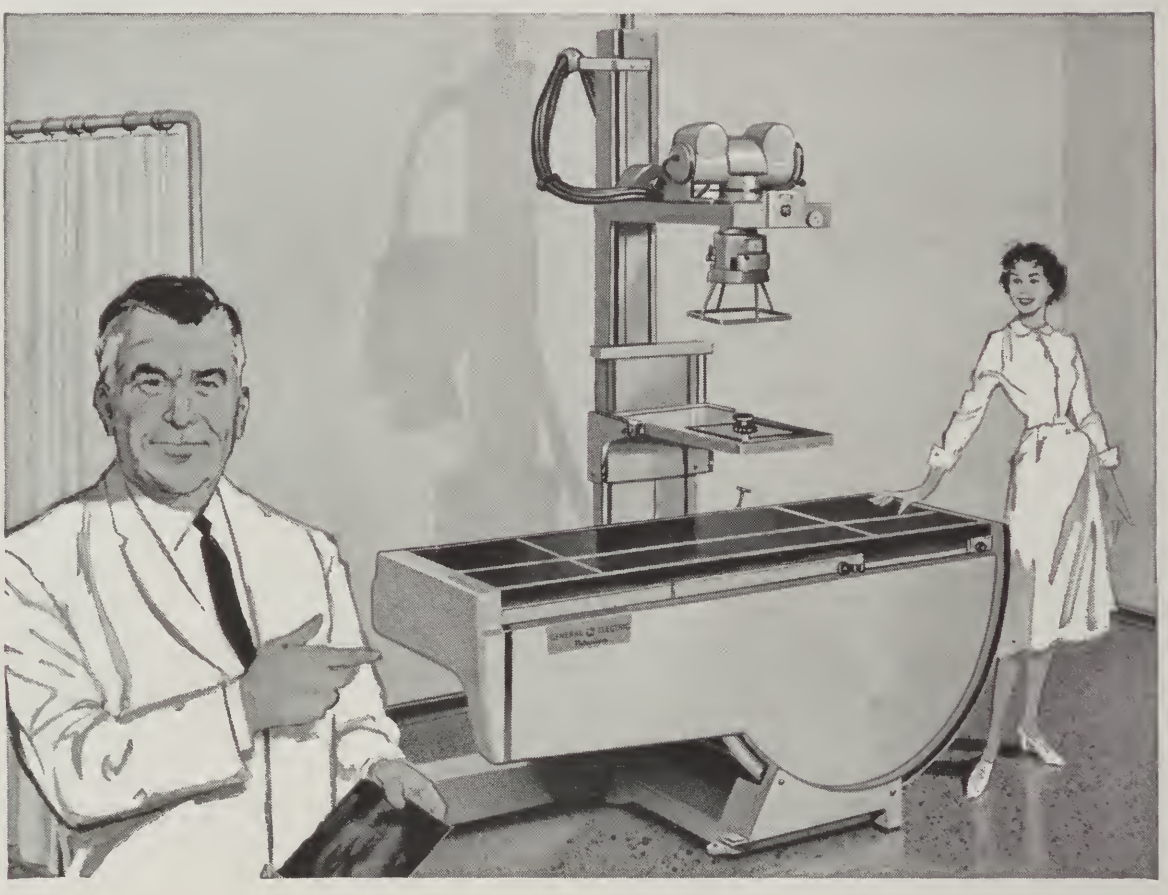
A 1911 graduate of the Louisville Hospital College of Medicine, Doctor Weddle practiced in several counties of Southeastern Kentucky before moving to Somerset in 1944. During his long career he delivered more than 7,000 babies.

An opening for a physician at Oak Ridge National Laboratory is announced by T. A. Lincoln, M.D., medical director of the East Tennessee industry. The position is salaried and offers regular hours, fringe benefits, paid vacations and an opportunity for some epidemiological research experience. A young physician with general practice experience is preferred for the post.

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1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378 (Nov.) 1956. 2. Boger, W. P.: In: Antibiotic Annual 1958-1959, Medical Encyclopedia, Inc., New York. 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959.

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SYNOPSIS OF GYNECOLOGY: by Robert James Crossen, M.D.; Daniel Winston Beacham, M.D., and Woodard Davis Beacham, M.D.; published by C. V. Mosby Company, St. Louis; 340 pages; price, $6.50.

This small concise book is a very complete didactic, well-organized synopsis on gynecology. The book is designed primarily for medical students and practicing physicians who do not devote their entire work in gynecology.

This synopsis is extremely well organized in a logical manner, and the chapters on anatomy, physiology, gynecological examination and diagnosis are very complete in every detail. I was especially impressed by these chapters for medical students.

Controversial subjects and opinions as to management and therapy of various conditions were quite properly avoided.

The two new chapters, one on endometriosis and one on pregnancy complications, are excellent and up-to-date in every respect.

Psychosomatic aspects of gynecology are summarized in the chapter dealing with the examination and diagnosis, and should be read and kept available as a reference by all physicians as well as medical students.

I was also impressed by the last short chapter ending the book on medicolegal points in gynecology. Many students and physicians, including specialists in gynecology, have a lack of knowledge regarding responsibilities to the patient, their families, and the medicolegal aspects related thereto.

This is one of the best synopses on gynecology that I have read. I highly recommend it to the profession as a reference book, and I think it will be especially valuable for the medical student.

J. B. Marshall, M.D.

THE CLONAL SELECTION THEORY OF ACQUIRED IMMUNITY: by Sir Macfarlane Burnet; published by Vanderbilt University Press, Nashville, Tennessee; 1959; 209 pages; price, $5.

This book represents an elaboration of the Abraham Flexner Lectures delivered at the Vanderbilt University Medical School in 1958.

The author is noted for many previous contributions of a theoretical and practical nature to the medical sciences and has been responsible for numerous novel and imaginative concepts. The substance of these lectures is in keeping with the author's biological approach to disease and health.

His basic view here is that the capacity to create specific antibody is a genetic property of a clone or family of cells so concerned, and that the effect of the antigen—better thought of as antigenic determinants—is merely to stimulate the cells which are already competent to do so into the proliferation of specific antibody production and other responses. These other responses include the phenomena of immunological tolerance, the hay fever type of antibody response and the tuberculin type of response. A short discussion of the somatic mutation theory of cancer ends the author's discussion.

The author is clearly a Darwinian evolutionist; to him just as the evolution of free living organisms in changing natural environments is related to survival, so does he view the mutation and selective growth of cell clones best fitted to survive for a given purpose in terms of immune response.

There are many provocative imaginative speculations here which will titillate the imagination of anyone interested in the basic dynamics of any disease in which immune bodies or cancer is involved which, therefore, impinges upon seemingly unrelated areas of medicine.

Alex J. Steigman, M.D.

RELIGION AND NURSING: by Samuel Southard, Th.D.; published by Broadman Press, Nashville, Tenn.; 209 pages; price, $4.75.

In this much needed volume a competent author has given us a pioneer work. Written to nurses primarily, it is nevertheless a valuable aid to doctors, hospital chaplains and others involved in a ministry to the sick.

The author's purpose is "to lead the nurse toward sources of spiritual strength which will sustain her" as a professional person and "to relate religious resources to the nurses' work with patients." This he does by drawing upon the insights of both the theological and psychological disciplines. The reader is led to see how the resources of Protestant Christianity are relevant to such areas of concern as suffering, guilt, doubt, terminal illness, bereavement, interpersonal and nursing ethics. The Biblical and theological heritage of the nursing profession provides the context in which Doctor Southard discusses these topics.

The clinical orientation of the author is evident in the careful use of illustrations and verbatim records of conservations. Appropriate use of relevant literature strengthens the observations and conclusions of the author.

Though a member of the Southern Baptist denomination, he writes as a Protestant in such a way as to speak to the concerns shared in common by many church bodies for the sick, dying and bereaved. His frankness and forthrightness are refreshing in a day

(Continued on Page 640)

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IN HYPEREMOTIVE ADULTS does not impair mental acuity	"...especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

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IN THE BOOKS

(Continued from Page 638)

when much writing seeks to obscure rather than clarify the author's position.

Doctor Southard is associate professor of psychology of religion at the Southern Baptist Theological Seminary in Louisville. Prior to this he was professor of pastoral psychology at the Institute of Religion, Texas Medical Center, Houston, Texas. A man who has worked closely with doctors and nurses for many years, he is well qualified to write on this subject. His volume is further evidence that sound scholarship and depth of religious experience can be blended in an effective and useful way.

Nurses and doctors alike can benefit from a study of this volume which seeks to view persons as created in the image of the One who, after all, is the source of all health and healing.

John H. Boyle
Executive Chaplain
Louisville Medical Center

WASHINGTON NEWS DIGEST

(Continued from Page 560)

charges" which constituted "an absolute disservice to the country."

James A. Appel, M.D., Lancaster, Pa., a member of the AMA Board of Trustees, testified before the Senate Subcommittee that the greatest health problem faced by older people is "their isolation from the rest of society." He said:

"The health problems of the aged can only be solved within the context of total health. They involve far more than hospitals or a doctor's care. They involve the older person's other requirements in life, whether these be housing, recreation, community understanding and acceptance, the right to be useful, the courtesy of being treated as individuals, or the opportunity of living as self-reliant, respected members of society."

As for an aged person being denied medical care because of a lack of money, Doctor Appel said emphatically:

"Medical care is available to every man, woman, and child in the United States regardless of his or her ability to pay for it.

"That care is not now denied, nor will it be denied."

Arthritis Seminar Set in Florida

A Postgraduate Seminar in Arthritis and Related Diseases is set for June 11 and 12 at the Diplomat Hotel, Hollywood-By-the-Sea, Fla., immediately following the annual meeting of the American Rheumatism Association and immediately preceding the annual meeting of the American Medical Association. The Florida Medical Association is cooperating with the Florida Chapter of the Arthritis and Rheumatism Foundation in sponsoring the two-day scientific program.

The course is acceptable for eight hours Category I credit by the Academy of General Practice, announces Ralph E. Nollner, executive director of the foundation. Registration fee is $15.

The Arthritis and Rheumatism Foundation has announced three awards in the fundamental sciences related to arthritis for work beginning July 1, 1961. Deadline for applications is October 31, 1960. The awards are: Predoctoral Fellowships, limited to students who hold a bachelor's degree, with stipends ranging from $2,000 to $3,000 per year; Postdoctoral Fellowships, limited to applicants with M.D. and Ph.D. degrees or their equivalent, with stipends from $5,000 to $7,000; Senior Investigator Awards, made to candidates holding or eligible for "faculty rank," with stipends from $7,000 to $10,000. Application forms may be obtained from the Medical Director, Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, N. Y.

The 23rd annual exhibition of art works by American physicians will be held in conjunction with the annual convention of the American Medical Association in Miami Beach, June 13-18, it is announced by Lewis M. Johnson, M.D., president of the American Physicians Art Association. The show will include over 300 works of art in oil, water color, sculpture, crafts, photography and lithography. Further information may be obtained from the APAA secretary, Dr. Kurt F. Falkson, 7 East 78th Street, New York City.

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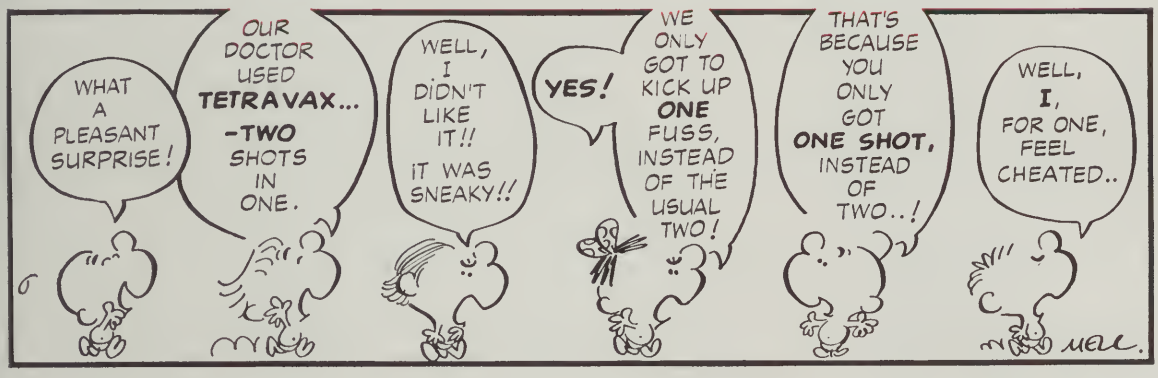
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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE # 39: This patient was a 21-year-old, married, white primigravida, who was approximately 2-2½ months pregnant. She had not consulted a physician until the day of her death. The history obtained from the patient's husband was that she had had some intermittent lower abdominal pain during the preceding month. Apparently this pain was not severe and was not accompanied by any vaginal bleeding.

About 30 minutes before she was seen by the physician, she had a sudden excruciating lower quadrant pain. This was so severe that she could not stand or walk. Her husband carried her three blocks to the physician's office. Upon arrival, she collapsed on the floor as her husband attempted to help her sit on a chair.

She was examined immediately and found to be pulseless with no audible blood pressure, but still breathing. About 20 minutes elapsed when the patient was hospitalized via ambulance; she was found to be dead on arrival.

With permission, the patient's abdomen was opened in the funeral home. There was a large quantity of free blood in the abdominal cavity plus a fetus and placenta which had been extruded explosively from the right tube. A large blood vessel was demonstrable at the site of rupture.

Cause of death: hemorrhage from a ruptured right tubal pregnancy.

Comment

The committee felt this was a direct obstetrical death for which the patient was responsible. Had she made her initial visit to her physician when she missed her first menstrual period, this death might have been prevented.

Ectopic pregnancy is probably the most commonly misdiagnosed disease in the female pelvis. In an English surgical text, the late Dr. W. O. Johnson is quoted, urging physicians to be always "ectopic conscious." Race does not seem to be an etiological factor. The tendency for it to recur is established. The possibility of a second occurrence is approximately ten times greater in women who conceive after having an ectopic than in women who have never had an ectopic pregnancy. The above case typifies the surgical emergency with the usual fatal outcome in untreated cases.

Every twelfth maternal death in Chicago and every sixteenth in New York is the result of ectopic pregnancy. Of the 25 maternal deaths in Kentucky in 1958 two were proven ectopics. This again calls attention to the value of the autopsy, without which the correct diagnosis in the above case would have been doubtful.



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PUBLIC HEALTH PAGE

The Effect Of Cancer Diagnosis On Cancer Data

RUSSELL E. TEAGUE, M.D.

Commissioner of Health
Commonwealth of Kentucky

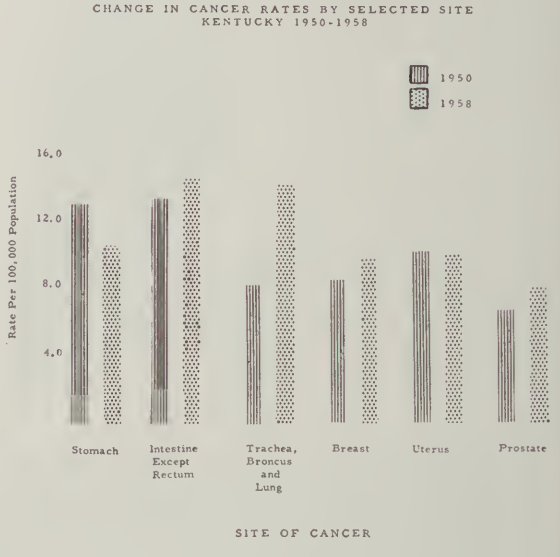
CANCER deaths in Kentucky, as in the rest of the United States, are steadily increasing. Kentucky deaths due to cancer increased from 3,252 in 1950 to 4,037 in 1958. In the face of better diagnostic and treatment facilities, why should such an increase occur? Is it a true increase or only a statistical manipulation? Since demographers tell us that there are more people alive now, does it not follow that more people die each year? In 1950, 27,706 Kentuckians died from all causes, while in 1958, the total was 29,395. What does this mean in terms of our cancer problem?

In order to compare our two sets of figures, we must find a common factor. In 1950, the population of Kentucky was 2,957,018; therefore, the 3,252 cancer deaths represent 110.0 deaths for every 100,000 residents of the State. By 1958, the population had increased to 3,032,400; therefore, the 4,037 cancer deaths represent 133.1 deaths from cancer for every 100,000 residents. Thus, for every 100,000 people in Kentucky, there were more deaths reported due to cancer in 1958 than in 1950.

One commonly accepted reason for this rise is the increase in average length of life. "More people escape the communicable diseases and live long enough to develop cancer," is an often quoted statement. If this is so, should not the deaths from cancer of various sites all increase proportionately? That they have not done so is suggested by the accompanying graph which compares cancer death by site in the years 1950 and 1958. Rates for cancer of the stomach and cancer of the uterus have decreased slightly. Rates for cancer of the intestine, breast and prostate have increased slightly, while the combined rate for cancer of trachea, bronchus and lung has increased 75% in the eight-year period.

What are some of the causes for the changes we have noted? Is more accurate diagnosis merely shfiting cause of death from some other condition to cancer? Have improved diagnostic and treatment techniques in some types of cancer resulted in earlier diagnosis and a greater rate of successful treatment? Is it possible that the causative agent or human susceptibility or both are changing in such a manner that there is a real shift in the incidence of cancer from one site to another? It seems evident that even though cancer is widespread, only a limited number of individuals are susceptible to it. Can a factor of this susceptibility, such as differences in distribution of enzymes in the blood serum, be identified?

In order to answer these questions and many others of a similar nature, there is a need for research into the nature of the host and the host-disease relationship, as well as the nature of the disease itself. The National Institutes of Health report on cancer studies now in progress gives strong indication that cancer



is a group of diseases with a variety of clinical manifestations suggesting that efforts for improving cancer diagnosis should be aimed toward development of at least several diagnostic procedures.

It is evident that significant contributions to our total knowledge of cancer are being made at an ever increasing pace. Obviously, diagnosis and reporting are the fundamental bases for much new research as well as for comparing Kentucky experience with that of other states and the nation as a whole. Concentration in this area can only result in improved cancer information for use by Kentucky physicians.

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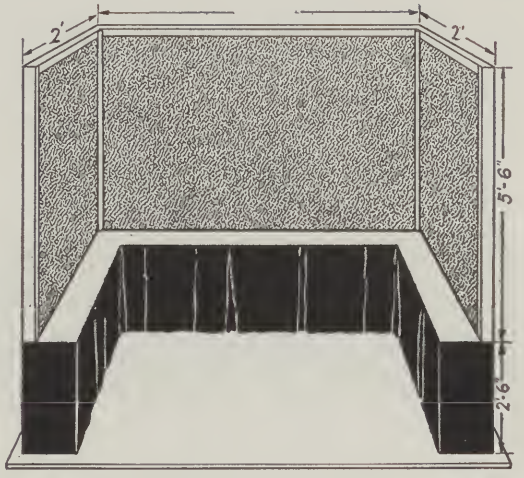
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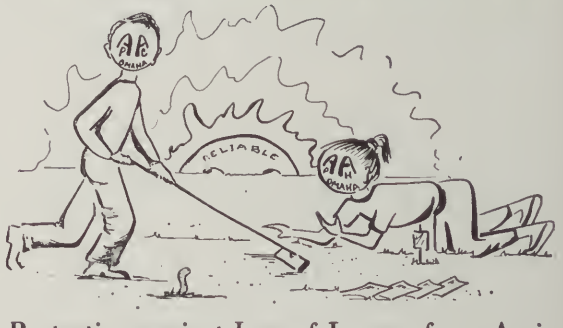
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Because of the infrequency of the disease in this age group, its sudden onset, the profusion of inconsistent presenting symptoms, and because the accompanying symptoms of anorexia and vomiting are also characteristic symptoms of many other ills of infancy.

*Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes *8*:289, 1959.

for those pediatric puzzlers..."A routine urinalysis and blood sugar should be done whenever the possibility of diagnosing diabetes is entertained."*

DIABETES MELLITUS AT AGES 1 TO 5

Order of Frequency of Presenting Symptoms in 110 Patients

Symptoms	No. of Patients	Per cent of total group
Polyuria	93	84.5
Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
Headache	1	0.9
Abdominal cramps	1	0.9

Adapted from Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.*

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N.B.: For information on dosage, side effects, cautions and contraindications, see available comprehensive literature, PDR, or your S.K.F. representative.

1. Goddard, E.S.: in *Trifluoperazine, Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959.

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INDEX MEDICUS



The JOURNAL of the Kentucky State Medical Association

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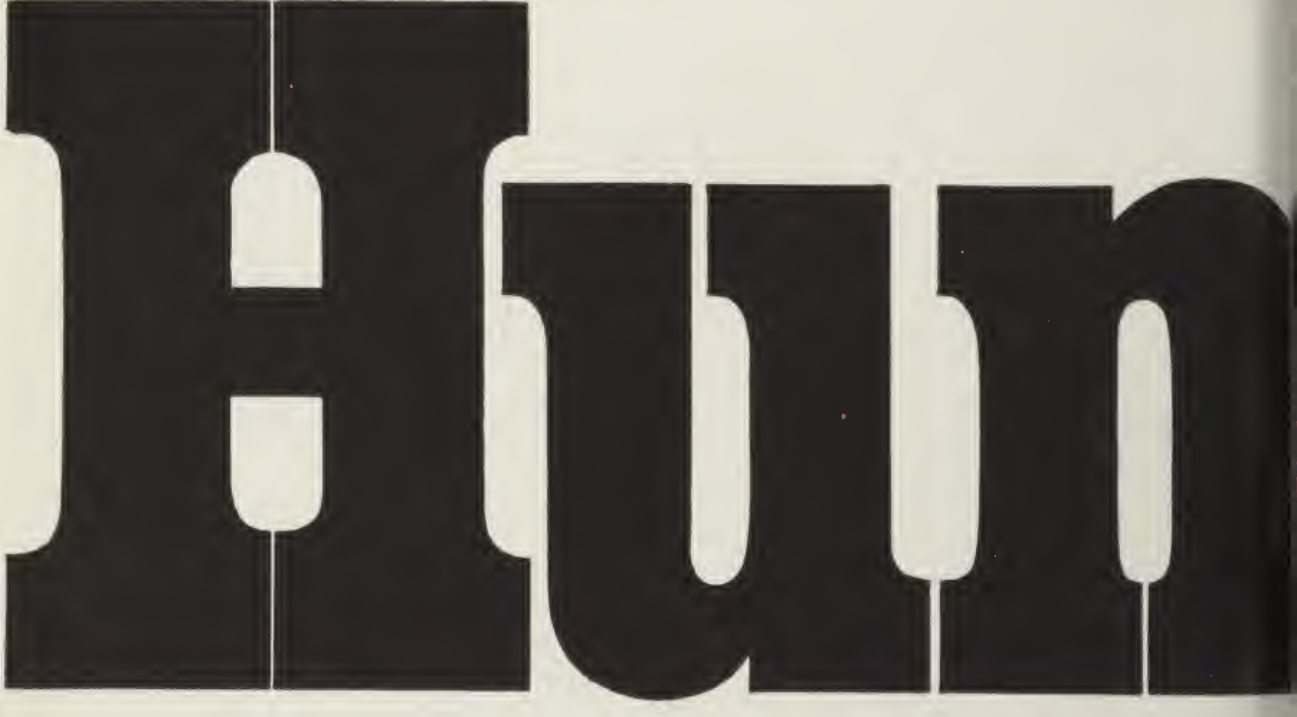
JUNE 1960 · VOLUME 58 · NUMBER 6

FROM PARKE-DAVIS...A NEW ORAL ANTIBIOTIC WITH EFFECTIVE ANTIBACTERIAL & ANTIAMEBIC ACTIONS

"THE FORTUNATE COMBINATION OF HIGH ANTIAMEBIC AND ANTIBACTERIAL ACTIVITY AND LOW ORAL TOXICITY MAKES PAROMOMYCIN UNIQUE AMONG THE AVAILABLE DRUGS AND SUGGESTS THAT IT SHOULD BE A USEFUL THERAPEUTIC SUBSTANCE."[1]

● **IN INFECTIOUS DIARRHEAS**[2-5] Because it is effective against gram-negative pathogens, HUMATIN has proved especially valuable in infectious diarrheas, most of which are caused by bacilli of the gram-negative group. In 221 patients with severe diarrhea, 85 per cent obtained rapid remission of symptoms with HUMATIN, and stools cleared quickly of pathogens.[2] Results in *Shigella* and *Salmonella* enteritis,[5] and in infantile diarrheas of mixed etiology[3] have been uniformly good.

● **IN INTESTINAL AMEBIASIS**[2, 5-8] HUMATIN is unusually effective in clearing all phases of intestinal amebiasis;[5] to date, more than 700 patients have been treated successfully with HUMATIN in all parts of the world. Since HUMATIN is not appreciably absorbed from the gastrointestinal tract it is not effective against extraintestinal forms of amebiasis.



ALSO VALUABLE IN THE PREOPERATIVE SUPPRESSION OF INTESTINAL FLORA,[2] AND IN THE ADJUNCTIVE MANAGEMENT OF HEPATIC COMA [9-11]

ADMINISTRATION AND DOSAGE

(expressed in terms of base)

Condition	Dosage (daily, in divided doses)	Duration of Therapy
Infectious Diarrheas (bacillary and nonspecific)	*Adults:* 35 to 50 mg/Kg; up to 100 mg/Kg in severe cases.	Up to 7 days
	Children: 50 mg/Kg; up to 100 mg/Kg in severe cases.	Up to 7 days
Intestinal Amebiasis (acute, subacute, chronic)	*Adults:* 0.75 to 1.5 Gm.; larger doses when required.	5 days
	Children: 22 mg/Kg; larger doses when required.	5 days
Preoperative Suppression of Intestinal Flora	*Adults:* 2 Gm.	4 days
Hepatic Coma	*Adults:* up to 6 Gm., depending on degree of hepatic insufficiency and response of patient.	See literature

SIDE EFFECTS: Since HUMATIN by the oral route is virtually nonabsorbed in the gastrointestinal tract, even with exceptionally high doses, systemic toxicity has not been a problem in clinical use.[2,3,5-8] However, when doses in excess of 2 Gm. per day are given for more than three days, loose stools may develop; on doses of from 4 to 6 Gm. daily, moderately severe diarrhea has been reported in some patients. No other indications of toxicity have been observed.

SUPPLIED: HUMATIN (paromomycin, Parke-Davis) is available as the sulfate in Kapseals,® each containing 250 mg. of base, in bottles of 16. Literature supplying details of dosage and administration available on request.

REFERENCES: (1) Coffey, G. L., *et al.*: *Antibiotics & Chemother.* 9:730, 1959. (2) Personal Communications to the Department of Clinical Investigation, Parke, Davis & Company, 1959. (3) Godenne, G. D.: Paromomycin in diarrheas of infants and children, Antibiotics Annual 1959-1960, New York, Medical Encyclopedia Inc., in press. (4) McMath, W. F. T., & Hussain, K. K.: *Pub. Health* 73:328, 1959. (5) Courtney, K. O., & Thompson, P. E.: Paromomycin as a therapeutic substance for intestinal amebiasis and bacterial enteritis, Antibiotics Annual 1959-1960, New York, Medical Encyclopedia Inc., in press. (6) Shafei, A. Z.: *Antibiotic Med. & Clin. Therapy* 6:275, 1959. (7) Elias, F. L., & Oliver-Gonzales, J.: *Antibiotic Med. & Clin. Therapy* 6:584, 1959. (8) Carter, C. H.: *Antibiotic Med. & Clin. Therapy* 6:586, 1959. (9) Fast, B. B., *et al.*: *Arch. Int. Med.* 101:467, 1958. (10) Mackie, J. E., *et al.*: *New England J. Med.* 259:1151, 1958. (11) Stormont, J. M., *et al.*: *New England J. Med.* 259:1145, 1958.

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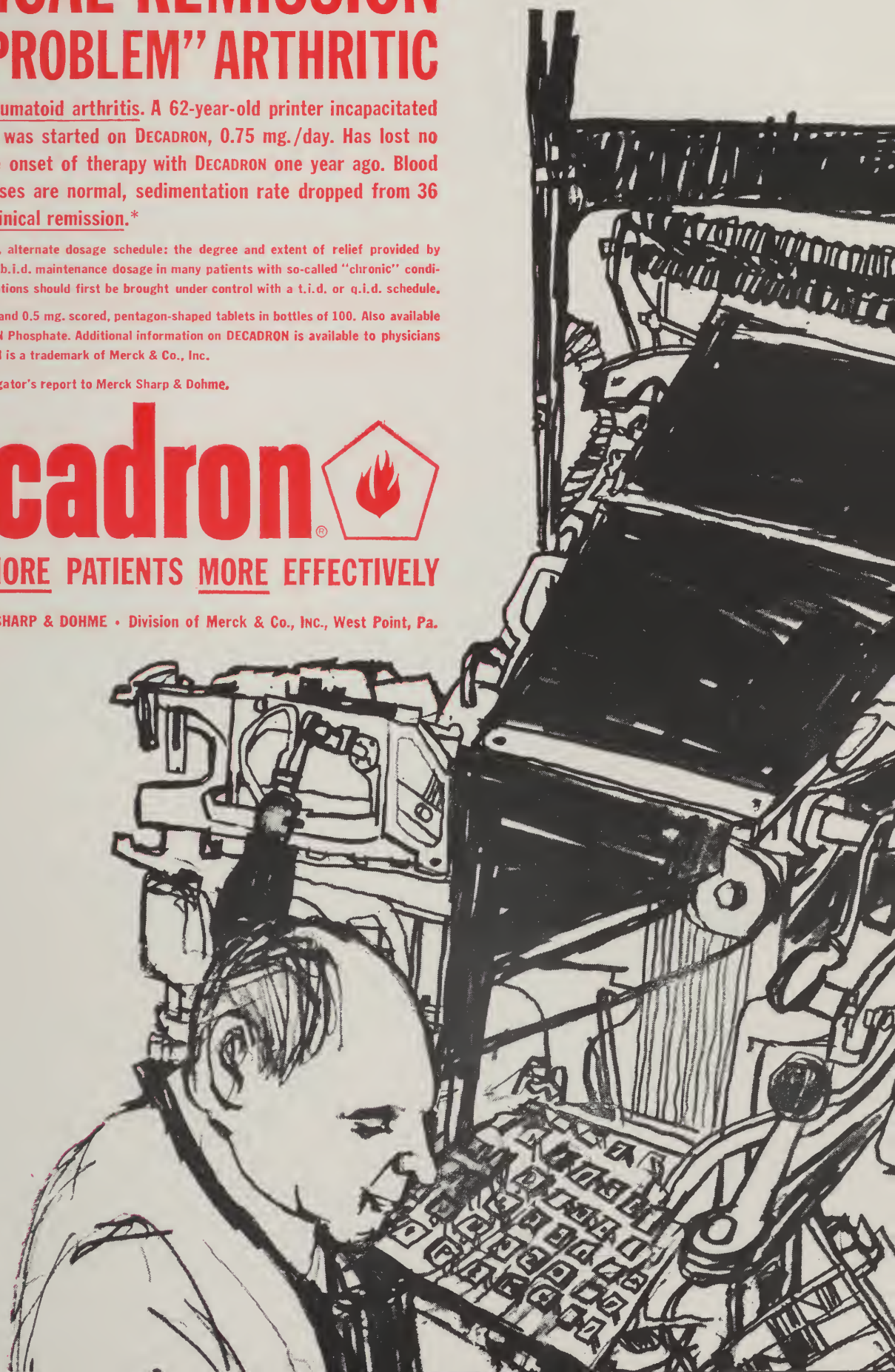
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HEAD: temporomandibular muscle spasm • NECK: acute torticollis, osteoarthritis of cervical spine with spasm of cervical muscles, whiplash injury • TRUNK AND CHEST: costochondritis, intercostal myositis, xiphodynia • BACK: acute and chronic lumbar strains and sprains, acute low back pain (unspecified), acute lumbar arthritis and traumatic injury, compression fracture, herniated intervertebral disc, post-disc syndrome, strained muscle(s) • EXTREMITIES: acute hip injury with muscle spasm, ankle sprain, arthritis (as of foot or knee), blow to shin followed by muscle spasm, bursitis, spasm or strain of muscle or muscle group, old fracture with recurrent spasm, Pellegrini-Stieda disease, tenosynovitis with associated pain and spasm.

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Dr. Hayes
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President's Page*

Past 65

THIS country in 1960 finds itself with 15 to 16 million people over 65 years of age and this age group is increasing at the rate of 300,000 people per year. Due to the fast pace of business and industry, the highly skilled technicians required in many jobs and compulsory retirement at age 65, many of these people are without gainful employment. This large group of our population is subject to illness just like any other group. In many instances, their ills differ in that they are long drawn out and chronic, requiring prolonged supervision and nursing care.

A great percentage of these people have scarcely any savings and are wholly dependent on a small pension, Social Security or some welfare agency. It has been shown that some 4,000,000 probably have enough to live on and care for themselves the remainder of their days. Another 4,000,000 are entirely dependent on old age pensions and welfare agencies. How are these people's medical needs to be met?

I feel their needs are being very well met by the profession in many communities. If this were not a presidential election year, I doubt we would see so many articles on this subject in every magazine we chance to read. Fifteen million votes count.

I feel here is one great challenge to the health insurance business. When new ills arise we must investigate and apply new remedies. Almost no health insurance coverage existed 20 years ago for Americans of advanced years.

As late as 1952, only 26 per cent of the public 65 years and older were covered by some type of health insurance. Today, reliable estimates show that at least 40 per cent of this group have some form of health-care protection and the number insured is rising more rapidly than the number of persons entering this age bracket. The insurance business should recognize the need for an intensive effort to provide adequate programs for the aged to help them insure themselves against the cost of medical care.

Legislation such as the Forand type is not the answer. It will be too expensive and will cover one group well able to care for themselves. It fails to cover that large group not covered by Social Security—the group now taken care of by various welfare agencies. Any compulsory health plan under Social Security would result in poorer, not better, health care for our people.

Medical care is not susceptible to production-line technique. It requires flexibility and this would tend to vanish the minute the government established a health program calling for mass treatment.

Communities and local governments would do well to think of establishing and expanding existing nursing-home facilities for the care of these people. Many of them do not need long, expensive hospital care.

Rex E. Hayes, M.D.
Vice-President—Western

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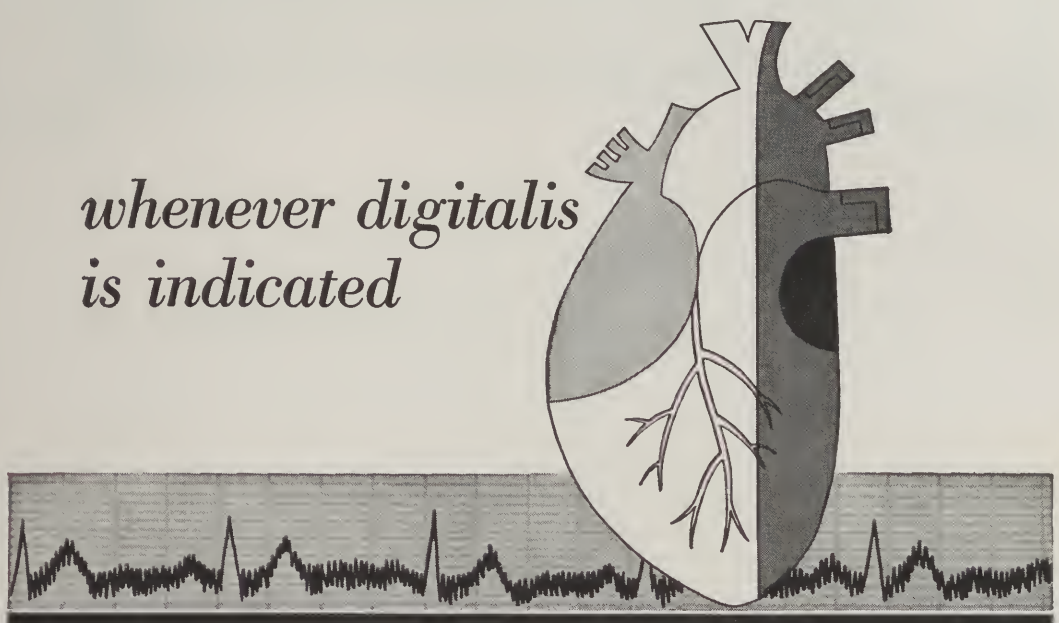
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THE INSURANCE PAGE



Medical Prepayment And Our Social Philosophy

"A CURIOUS paradox of some contemporary social philosophy is the idea that man should spend what he earns for his pleasures rather than for what he needs. It is appropriate, so this reasoning goes, that he should buy a television set, a vacation in Florida or an outboard motor boat, because these are cardinal rights. But for something that he really needs, such as his life or his health, or the life of his child, someone else should pay. This may be the Government, his employer, his union, his great-aunt or anyone else who can be cajoled or coerced into paying the price for him. If no one else will pay for it, the doctor should serve him for nothing."

This observation by C. Marshall Lee, Jr., M.D.,* raises a question of crucial importance not only to the medical economy but to the whole pattern of our American society.

For, as Doctor Lee puts it, the attitude he describes "may be acceptable for the child of an indulgent parent, but it is not appropriate for a free man in a free society."

What can the doctor do to counteract this philosophy and to forestall the socialization of medicine which may be its ultimate product?

First, the doctor should learn all he can learn about our voluntary medical prepayment programs. Physicians should recognize that, in Doctor Lee's words, "Far from being the meddlesome 'third party' for which they have an uneasy fear, (the prepayment program) stands with them in the common effort to preserve a cherished concept of freedom."

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Finally, the medical profession's own sponsored Blue Shield Plans offer the American doctor an opportunity not only to strengthen and confirm his patient's confidence in our traditional way of practicing medicine, but also to participate actively in guiding the destiny of our medical prepayment program in the days ahead.

---

*"*The Challenge of Medical-Care Insurance," C. Marshall Lee, Jr., M.D., Assistant Medical Director, John Hancock Mutual Life Insurance Company, The New England Journal of Medicine, 262:7, pp. 332-42, Feb. 18, 1960.*



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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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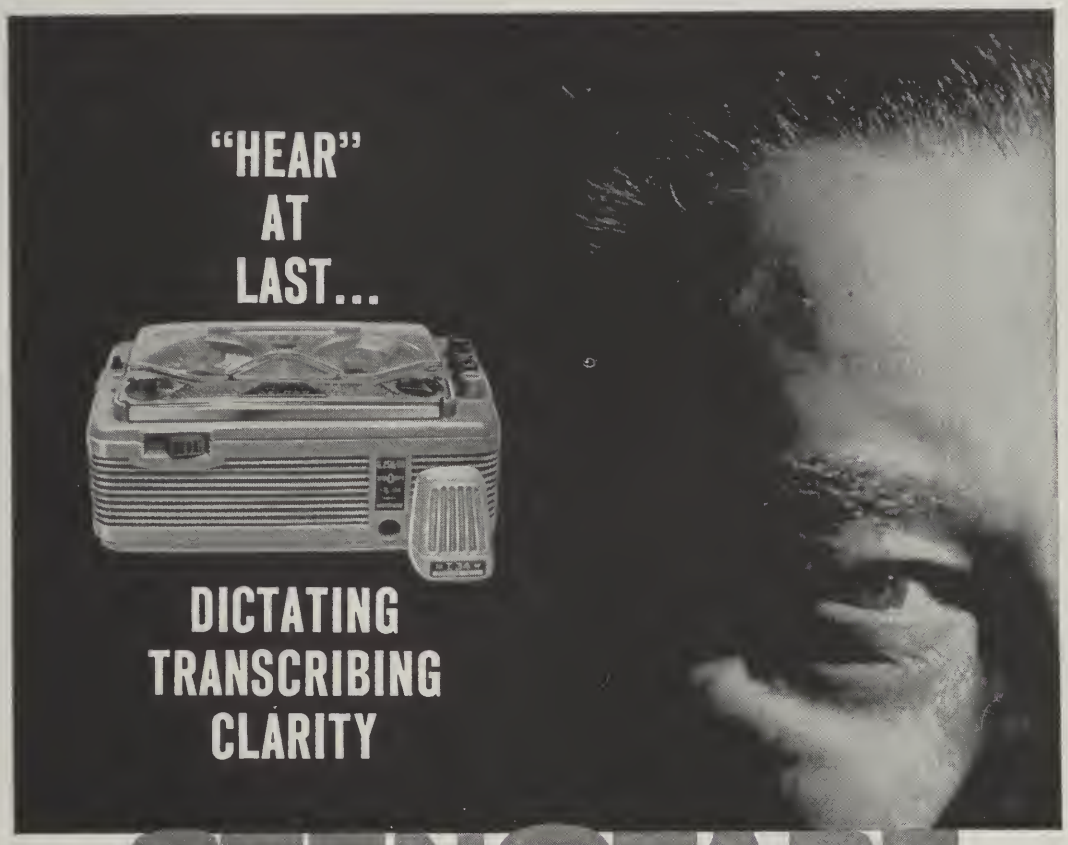


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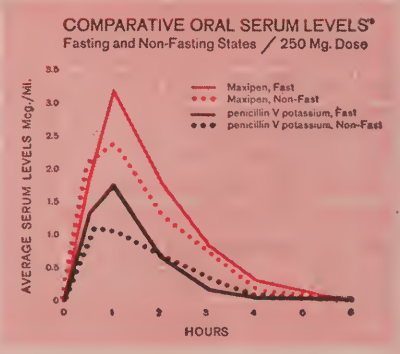


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Lichtman[1,2] used Trancopal to treat patients with low back pain, stiff neck, bursitis, rheumatoid arthritis, osteoarthritis, trauma and postoperative muscle spasm. He noted that Trancopal brought satisfactory relief to 817 of 879 patients (excellent in 268, good in 448, fair in 101). "Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[1]

Gruenberg[3] also prescribed Trancopal for 70 patients with low back pain and observed that it brought marked improvement to all of them. "In addition to relieving spasm and pain, with subsequent improvement in movement and function, Trancopal reduced restlessness and irritability in a number of patients."[3] In another series of 193 patients Kearney[4] obtained relief with Trancopal in 181 patients suffering from low back pain and other forms of musculoskeletal spasm.

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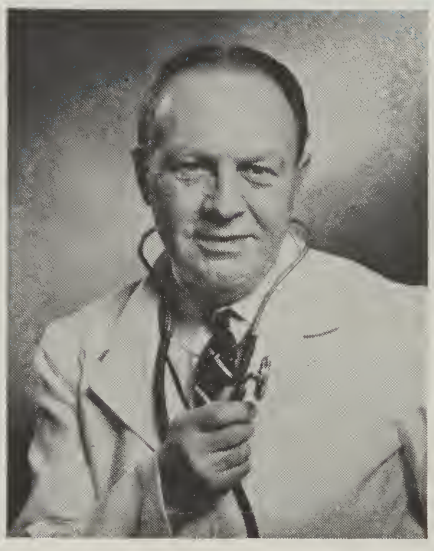
References: 1. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958 • 2. Lichtman, A. L.: Scientific Exhibit, Internat. Coll. Surgeons, Jan. 4-7, 1959, Miami Beach, Fla. • 3. Gruenberg, F.: *Current Therap. Res.* 2:1, Jan., 1960 • 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960 • 5. Collective Study, Department of Medical Research, Winthrop Laboratories.



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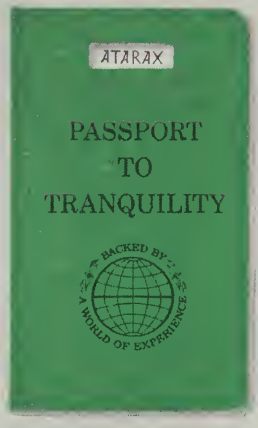
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IN HYPEREMOTIVE ADULTS does not impair mental acuity	"...especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

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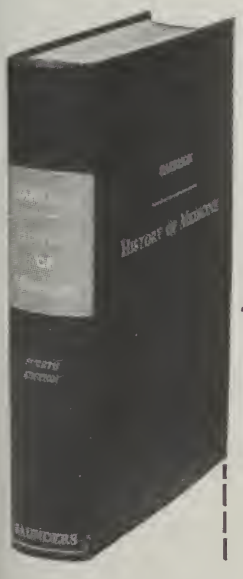
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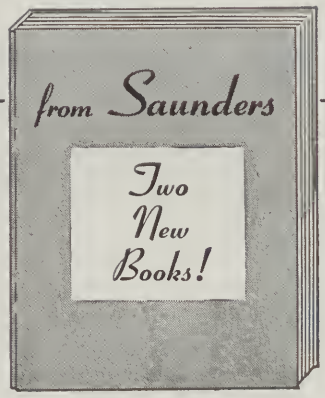
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WASHINGTON NEWS DIGEST



WASHINGTON, D. C.—Politics now overshadows all other factors in the issue of health care for the aged.

It appears certain to be a major issue in this year's campaigning for the White House and Congress, regardless of what Congress does in the field before adjourning this summer.

Both the Democrats and the Republicans are supporting costly, sweeping plans which differ on the basic approach. The major Democratic plans call for use of the Social Security System. The Republican proposals would have the Federal Government and the states put up hundreds of millions of dollars to help the aged buy health insurance on a voluntary basis.

The medical profession and allied groups oppose these political solutions because, among many other important reasons, they actually would not meet the problems of many aged who need help in financing the cost of illness.

Delay of Action Urged

Meanwhile, a key Democrat—Rep. Burr Harrison of Virginia—warned Congress against acting on such legislation in this year of a national election. He predicted that if any such legislation should be approved this year, it "would be certain to be a monstrosity."

Noting that various solutions had been proposed, Harrison said:

"The only features which these proposals have in common are that they are all tremendously expensive; they all propose revolutionary change, and they are all complicated, uncertainly-based and little-understood by the prospective beneficiaries."

Harrison, who is a member of the House Ways and Means Committee which handles such legislation, urged that Congress defer action until next year. He recommended that, in the meantime, the Ways and Means Committee "conduct an exhaustive study of the various proposals."

Administration's Plan Opposed

In early May, the Eisenhower Administration unveiled a Federal-state, $1.2 billion-a-year plan to help the aged with limited incomes buy broad medical and hospital insurance coverage. Under the plan, an aged person—if able financially—would bear part of the cost of both the insurance and of the medical care and hospitalization.

Arthur S. Flemming, Secretary of Health, Education and Welfare, and Vice President Richard M. Nixon stressed that participation by the aged in the Administration program would be on a voluntary basis.

The Administration's plan immediately ran into widespread opposition. Louis M. Orr, M.D., Orlando, Fla., president of the American Medical Association, said it was based "on the false premise that almost all persons over 65 need health care and cannot afford it."

"This is not a fact," Doctor Orr said. "The truth is that a majority of our people are capable of continuing a happy, healthy and, in many cases, productive life. Of the more than 15 million persons in the nation over 65 years of age, only 15 per cent are on old-age assistance."

Doctor Orr said neither the Administration's proposal nor the Forand-type Social Security approach is tailored to meet the problems of the undetermined number of older persons who, "although able to finance other costs, find it difficult to withstand the additional burden of the cost of illness."

Doctor Orr advocated the AMA's positive eight-point program for the health care of the aged as a "sensible, economical" plan that would preserve freedom as well as promote security. If both these objectives are to be realized, Doctor Orr said, health care programs for the aged "must necessarily be limited to support for the needy aged and leave to voluntary, competitive private enterprise, those activities needed to improve the health care of the rest."

AMA Program Outlined

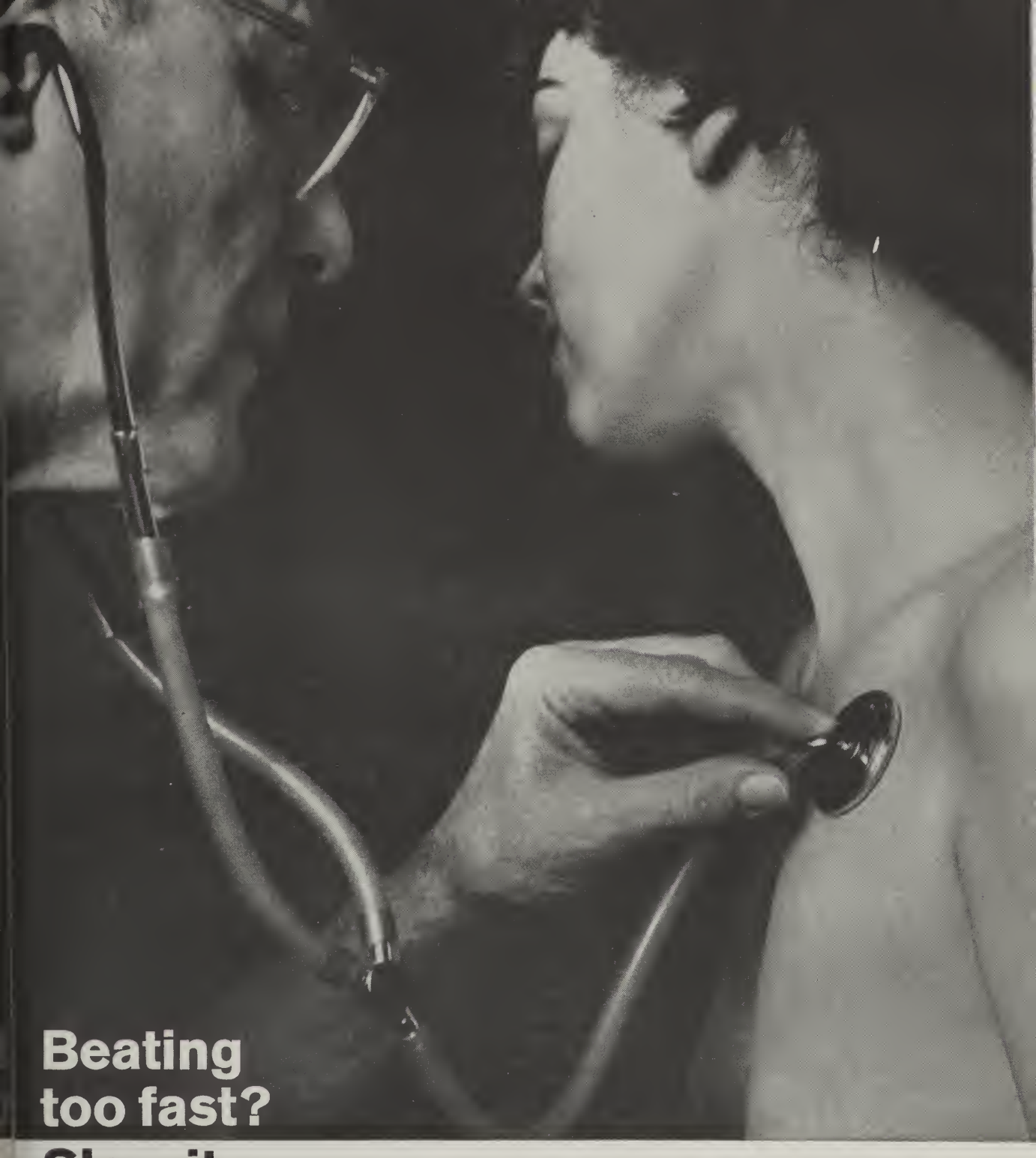
In brief, the AMA program comprises:

(1) Improved preventitive medical care for the aged; (2) a state-administered program of Federal grants-in-aid to states for liberalization of existing old-age assistance programs so that the near-needy could be given health care without having to meet the present rigid requirements for indigency; (3) better nursing home facilities for the long-term care of aged persons, especially those over age 75; (4) rapid development of health insurance and prepayment policies to provide long-term nursing home care;

(5) Expansion of home nursing care services; (6) elimination of compulsory retirement and a basic change in the attitude that a person who reaches 65 has suddenly become non-productive and senescent; (7) health education to instill a "will to live" in older persons and to make them aware of the need for continuing healthful nutrition; and (8) anti-inflationary curbs to maintain the purchasing power of fixed pension and annuity benefits.

A Republican lawmaker, Sen. Barry Goldwater of Arizona, denounced the Administration's plan as "socialized medicine" and a "dime store new deal." The outspoken conservative predicted its ultimate cost

(Continued on Page 741)



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References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.



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Recent JAMA editorial statement clarifies the current controversy about dietary fats

Excerpted from the March 12, 1960, issue of The Journal of The American Medical Association:

"It is accepted generally that specific alteration in the diet will lower the concentration of cholesterol in the blood. The most effective results to date have been achieved by increasing consumption of polyunsaturated fatty acids, particularly linoleic acid. However, indefinitive and conflicting information has left much to the imagination of some food processors. Some of the largest vegetable oil processors in the United States have implied in advertisements that the cholesterol level can be lowered merely by adding polyunsaturated fatty acids to the diet. This selling campaign has created confusion among lay people, making it increasingly important that the physician clarify for his patients the conditions under which changes in the diet will be effective.

The patient should understand that if he increases his consumption of polyunsaturated fatty acids without reducing his intake of other fats, little is gained save for additional calories which could lead to obesity. A particular regimen will be effective only if polyunsaturated fatty acids are responsible for an appreciable percentage of the total fat calories. That is, they must replace rather than supplement some of the saturated fats and oils already in the diet.

* * *

Some manufacturers cite the "iodine number" of a fat or oil as evidence of the unsaturated fatty acid content of their product. This number is not a reliable indicator of therapeutic value because it measures monounsaturated and polyunsaturated fatty-acid content at the same time. A monounsaturated acid, like oleic, takes up two iodine atoms but does not affect the cholesterol concentration of the blood. A polyunsaturated acid, like linoleic, takes up four iodine atoms. In a product containing large amounts of oleic acid and small amounts of linoleic acid, the iodine number is nearly the same as it would be for a product containing little oleic acid and a modest amount of linoleic acid. Cottonseed oil has an iodine number of 110 and corn oil a number of 127; yet they each have about the same amount of linoleic acid.

* * *

Low-fat diets will not reduce the concentration of circulating cholesterol and lipoproteins as effectively as will diets containing an adequate percentage of polyunsaturated fatty acids. Weight-reduction regimens are basically low in fat, and if a lowered cholesterol level is necessary, planning must be done to maintain the proper ratio of saturated to unsaturated fats."

* * *

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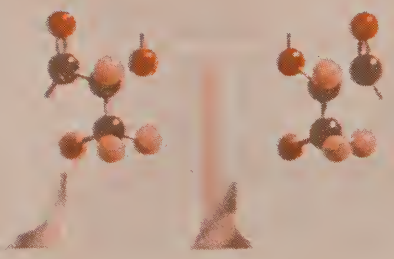
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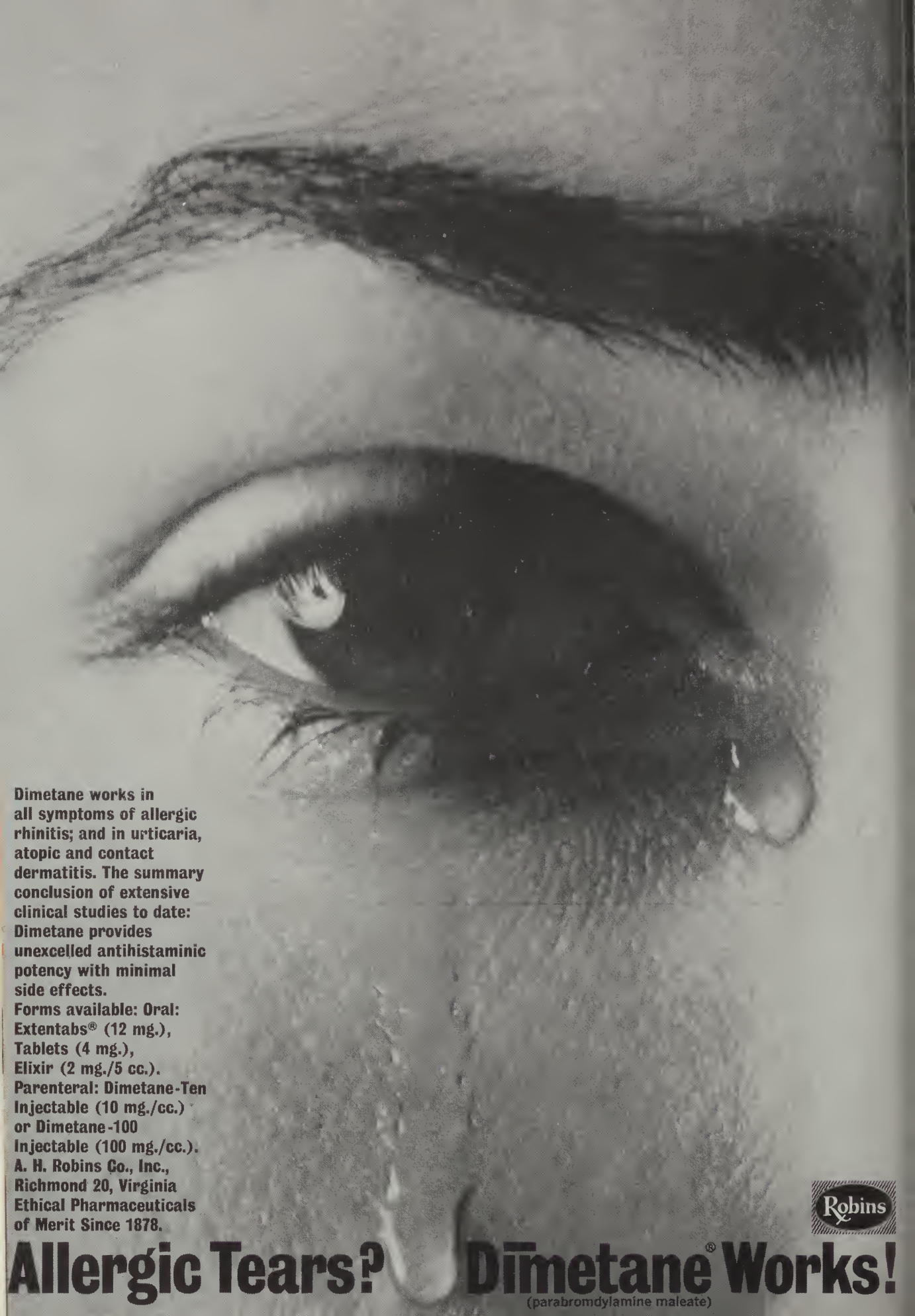
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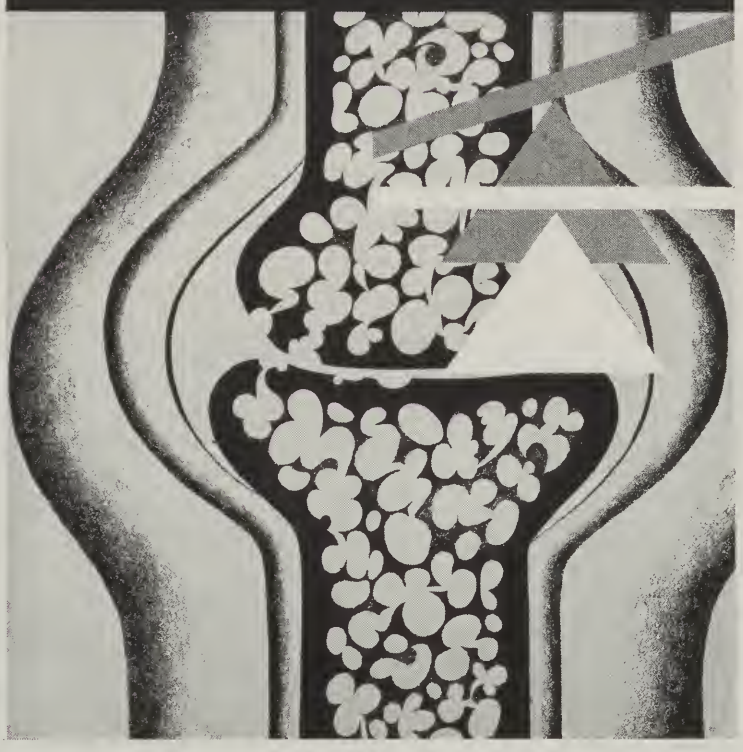
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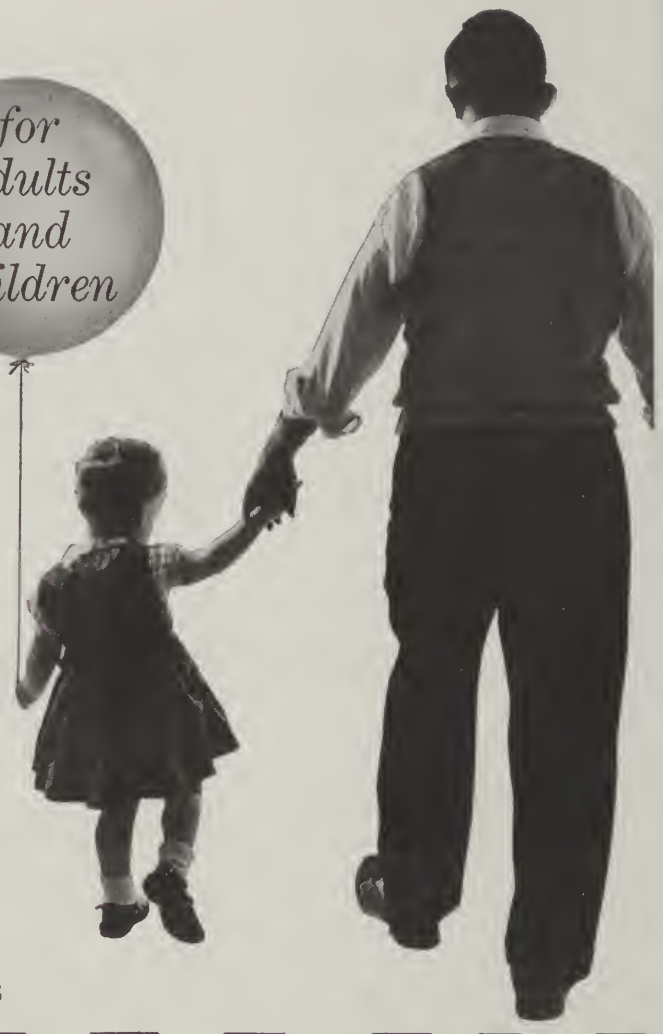
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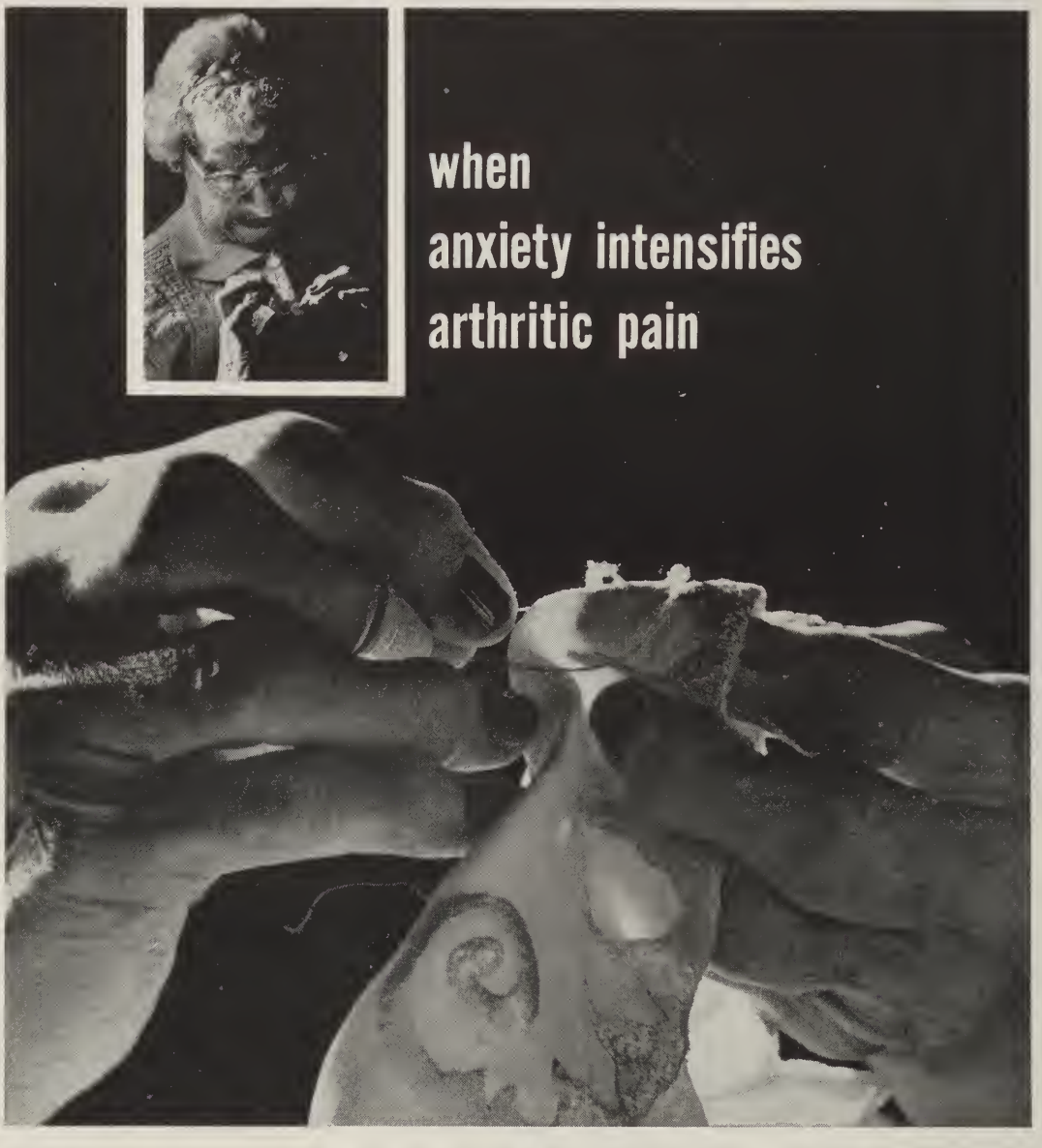
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An Evaluation Of the Isolation-Perfusion Technique In the Treatment Of Cancer

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WALTER I. HUME, JR., M.D. *Louisville, Ky.*
CONDICT MOORE, M.D.*

Patients with regionally confined tumors beyond surgical and radiotherapy are considered candidates for perfusion with cancerocidal agents. Six cases are presented

MANY malignant tumors are cured by surgical excision or radiotherapy. Others respond poorly to the standard types of treatment. Because of this dismal prognosis for certain patients, a wider interest in chemotherapeutic agents is being seen. Scores of cancerocidal agents have been developed, but often the dose necessary to destroy the neoplasm produces massive necrosis of normal body tissues.

From the observations by Klopp that the intra-arterial injection of nitrogen mustard into tumor bearing areas produced improved results,[11] has evolved the concept of isolation of the malignancy from the general circulation and perfusion with cancerocidal drugs.

The isolation-perfusion method has been used as palliative therapy in regionally confined but nonresectable lesions and as adjuvant treatment in cases in which the natural history of the lesion is especially unfavorable, or in patients in which the ablative surgery proposed would necessarily be mutilative, or morbidity from x-ray therapy prohibitive.[7, 10] Relief of pain which previously required excessive narcotics, chordotomy, or lobotomy has been observed. On many occasions the tumor has regressed or disappeared but many recurrences have been noted and at this juncture no actual cures of malignant disease can be substantiated for this technique.

Technique

The perfusion method is based upon anatomical isolation of a regionally confined neoplasm by inflow and outflow vessel control. The artery supplying the malignancy and the vein draining it are cannulated with plastic catheters and connected to an extracorporeal circuit which consists of two sigma motor pumps and a bubble oxygenator. An appropriate quantity of a carcinolytic agent is injected

Department of Surgery, University of Louisville School of Medicine and the Louisville General Hospital. Jackson — instructor in surgery; Hume — instructor in surgery; Moore—assistant professor of surgery.

slowly in divided doses via the arterial line proximal to the pump head for adequate mixing, as illustrated in Figure 1.

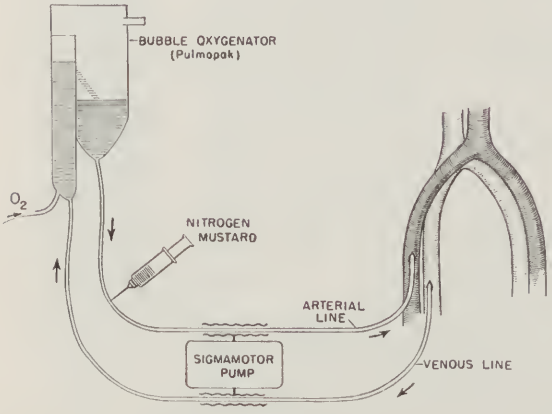


Figure 1

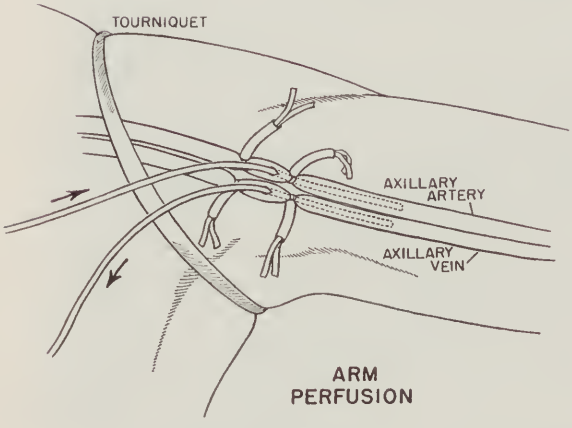


Figure 2

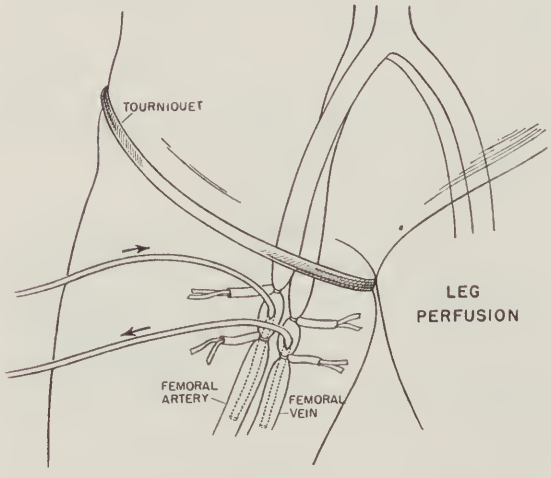


Figure 3

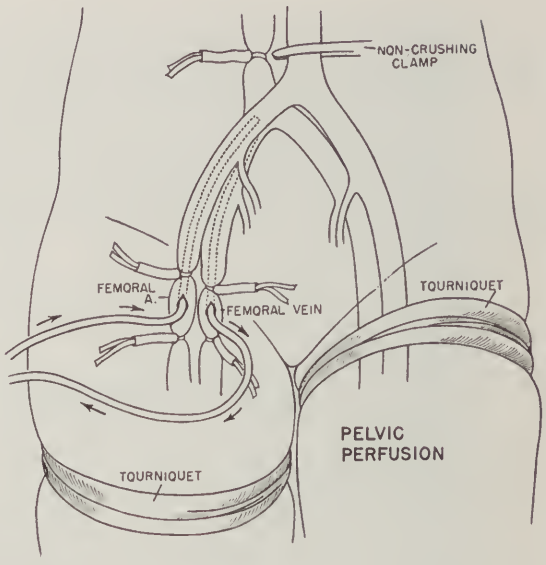


Figure 4

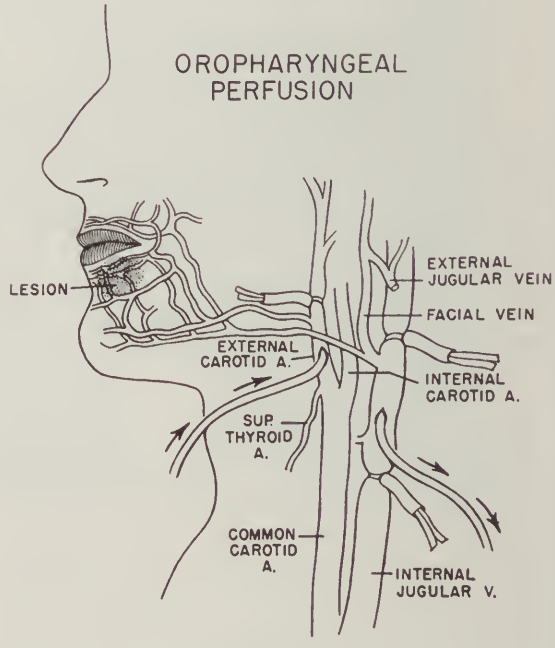


Figure 5

Perfusion time usually lasts about 30 minutes. This method has been easily adapted to the extremities. However, the pelvis, lung, liver, brain, and head and neck have been attacked successfully.[6, 14] Anti cancer agents effective enough to justify perfusion of the liver are not now available to us. Perfusion of the lung requires two separate extracorporeal circulations. Extremity, pelvic and oropharyngeal perfusions are illustrated by figures 2, 3, 4, 5.

Case Reports

We have used this approach in the treatment of malignancy in six cases. The case follow up extends over a period of sixteen months.

CASE #1: A 34-year-old woman had had right lower quadrant cramps, anemia, and gaseousness for two months. In April, 1958, she had an appendectomy and was thought to have adjacent inflammation of the cecum. Three months later she developed partial intestinal obstruction and was admitted to the Jewish Hospital, Louisville. A right colectomy and ileotransverse colostomy were performed for a grade 3 adenocarcinoma of the right colon and lymph node metastases. No other spread was noted. She returned four months later with recurrence in the cul-de-sac. The pelvis was perfused via the aorta with nitrogen mustard for 26 minutes, using 0.4 mg per kilogram of body weight, at a flow rate of 1000 cc per minute, with 100% oxygen saturation of the perfusate. The tumor was controlled for five months and then recurrence was noted. However, in the interim, there was moderate relief of back pain.

CASE #2: A 3½-year-old boy had an asymptomatic mass on the right mid forearm for 2½ months. In March, 1959, a wide local excision was done at the Children's Hospital for what proved to be a rhabdomysarcoma with extension to the resection edges. The axillary artery was perfused one week later with nitrogen mustard, using 0.6 mg. per kilogram of body weight, at a flow rate of 150 cc. per minute, for 30 minutes. The perfusate was 100% saturated with oxygen. There has been no recurrence since the perfusion (11 months at the time this report was written).

CASE #3: A 76-year-old man with extensive squamous cell carcinoma of the left lower lip with adherence to the bone was admitted to the Louisville General Hospital on October 8, 1959. The lesion was surgically curable but would have required partial resection of the mandible or radiation which might result in necrosis of the mandible. Therefore it was decided to perfuse the external carotid artery with nitrogen mustard (0.4 mg./KG). After the perfusion, considerable edema over the distribution of the external carotid artery was noted and a left facial palsy developed from what appeared to be inadequate mixing of nitrogen mustard in the arterial line. The central area of the carcinoma sloughed but viable tumor remained at the periphery. The tumor, however, has been under control without evidence of local or distant spread. Excision of the remaining carcinoma without resection of the mandible was carried out on January 21, 1960.

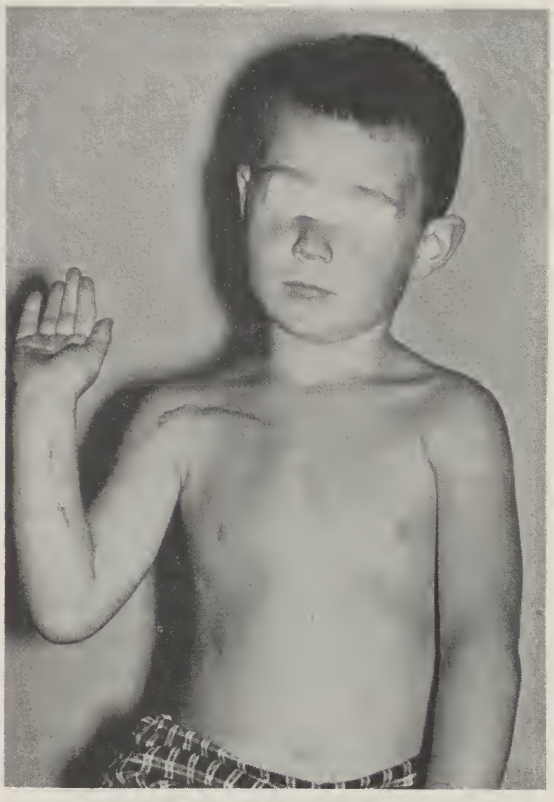


Figure 6

Child described in Case #2.

CASE #4: A 20-year-old housewife had a melanoma excised from her right proximal forearm one year ago, followed by an axillary dissection. Metastatic melanoma was found in the axillary nodes. A recurrence, confirmed by biopsy, was noticed in the right forearm one year after the original surgical procedure. A lytic lesion in the left pelvis was demonstrated on at least three x-rays at that time. On November 21, 1959, the right arm was perfused via the axillary artery with phenylalanine mustard (1.5 mg./KG.). The lytic lesion in the left

pelvis could not be demonstrated three weeks later by multiple x-ray views, including planigrams. However there was no histological proof that the lesion viewed on previous x-rays was actually a metastasis. Biopsy of a small nodule in the right arm showed no change in the melanoma. One week later, a wide excision of recurrent melanoma and draining lymphatics in the right arm was carried out. There had been no progression of the disease 11 weeks post perfusion. The white blood count dropped to 2100 per cmm. on the 24th postop day but gradually rose without steroids.

In cases 2, 3, and 4, perfusion of cancerocidal drugs was used as adjuvant therapy.

CASE #5: A 45-year-old female with carcinoma of the cervix, treated with radiation and Werthein hysterectomy, developed a left pelvic recurrence eight months after surgery. Her course was complicated by a partially blocked left ureter and severe back pains with radiation down the left leg. Pelvic perfusion with nitrogen mustard (0.8 mg./Kg.) was carried out on December 15, 1959. There was striking relief of pain but to date the tumor mass in the left pelvis remains unchanged. No complications were seen in this woman.

CASE #6: A 69-year-old colored female with regionally confined, inoperable, transitional cell carcinoma of the bladder was admitted to the Louisville General Hospital with hematuria and fever. The patient was difficult to evaluate because of senility but pain and hematuria appeared to be the important symptoms. She required constant attention and could not be discharged. Because of the persistent hematuria in the face of inoperability, it was thought that her plight might be improved by perfusion. Consequently, on December 30, 1959, she had a pelvic perfusion with nitrogen mustard (0.8 mg./Kg.) via the right femoral artery. Biopsy of her bladder on January 13, 1960, revealed acute and chronic cystitis without evidence of carcinoma, but malignant cells were found on bladder biopsy of January 29, 1960. The patient seems generally improved. The hematuria has lessened and discharge seems imminent.

Discussion

Creech and his associates at Tulane University are largely responsible for the application of isolation-perfusion techniques to the treatment of malignancy. This group has employed nitrogen mustard, phenylalanine mustard, thiotepa, actinomycin D., and 5 flurouracil for carcinomas, sarcomas, and melanomas. Major success was reported with extremity melanomas treated with phenylalanine mustard. In some cases there was striking necrosis of the tumor.[4, 5, 6, 7, 8, 13] Clark, at the M. D. Anderson Hospital, has reported similar results with phenylalanine mustard in the treatment of melanoma, but he has not been encouraged by the results from the use of other mustards in the treatment of gastrointestinal tract malignancy.[3] The consensus at the present time is that adeno-carcinoma of the G. I. tract responds poorly to perfusion with the mustards, but a variable response may be anticipated with 5 fluorouracil. One can expect fair to good results in breast carcinomas, rhabdomyosarcomas, Kaposi's sarcoma,[12] melanomas, and squamous cell carcinomas of the cervix and head and neck. There has been no claim of cure and none is being made here.

Certain advantages seem apparent with the isolation-perfusion methods:

1. Systemic toxicity of the mustards can be reduced by anatomical isolation of the neoplasm and drainage of the circuit of contaminated blood at the close of the procedure.
2. Much larger doses of cancerocidal drugs can be used without depression of the bone marrow or gastrointestinal symptoms.
3. A higher oxygen tension may be delivered via the heart-lung machine, thereby potentiating the effectiveness of the alkylating agents.[2]
4. The host antibody response to cancer remains unaltered.
5. A combination of drugs can be perfused simultaneously without additional risk.
6. An unresectable tumor may be rendered resectable following perfusion.
7. It appears to be the treatment of choice in extremity melanoma when multiple cutaneous metastases are present, necessitating hemipelvectomy or fore quarter amputation.

The cardinal disadvantage with this method lies in the lack of specificity of the cancerocidal agents. A solution to this problem may be forthcoming with the growth of tumor in tissue culture.[6] With this approach it would be possible to ascertain prior to perfusion whether a cancerocidal agent would be effective. Another troublesome handicap with the technique has been leakage into the systemic circulation via collateral vessels. Austen et al noticed the greatest leakage of cancinolytic agents in pelvic perfusion in patients with the venous return partially obstructed by a large tumor mass. They theorized that many collaterals, developed as a result of venous stasis, accounted for disproportionate spill over. Red cells tagged with radio active chromate were used to determine the critical leakage of nitrogen mustard or thio-tepa into the systemic circulation.[1]

No bone marrow complications have been seen in this small series of six patients, even though the granulocytic series invariably dropped to 4000 to 6000 per cmm. by the 15-20th day, excepting the patient perfused with phenylalanine mustard for melanoma, whose white count dropped to 2100 per cmm. on the 24th day postop.

No noteworthy gastro-intestinal symptoms have been observed. Wound infections were not seen in this group of patients. Our main complication has been edema with nerve damage in one case, from what was thought to be streaming of the drugs rather than adequate mixing.

As we become more familiar with the technical procedure and the effects of the various drugs, many of the older age group may be safely accepted as candidates for perfusion. The femoral approach for pelvic perfusion, by preventing massive spill over via the lumbar circulation and because of the technical ease with which femoral vessels can be cannulated, appears to be a safer procedure. Even with the available non specific drugs the effectiveness of the method may be altered by a combination of drugs, slower perfusion rates, temperature regulation, and optimum pH and oxygen saturation of the perfusate. These variables seem minor but appear to effect cellular metabolism remarkably.

Summary

The lack of drug specificity is the main drawback in the chemotherapy of malignancy. Isolation-perfusion techniques can be easily adapted to almost any organ of the body. Any patient who has a regionally confined tumor beyond surgical or x-ray management should be considered a candidate for perfusion treatment. Occasionally perfusion treatment may be employed as adjuvant therapy. There has been no mortality in this group of cases, and morbidity of consequence in only one of the patients.

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Modern Concepts In the Management Of Hepatic Coma*

Martin Seler Kleckner, Jr., M.D.†

Paducah, Ky.

Hepatic coma can be recognized by certain neuropsychiatric findings. That its cause is due to disease of the liver should be confirmed by hepatic function tests

HEPATIC coma should always be regarded at the present as a clinical condition. The syndrome of hepatic coma was recognized by Galen and Celsus. Hippocrates said "those who are mad on account of phlegm are quiet, but those on account of bile are voeiferous, vicious and do not keep quiet." In 1769 Morgagni described hepatic coma in a priest in whom restlessness and stupidity progressed to delirium, convulsions, coma and death. In 1860 Frerichs described the neuropsychiatric features of hepatic coma in his monograph, "A Clinical Treatise on Disease of the Liver." During this time acholia or cholemia allegorized hepatic coma, which was considered due to retention of bile.

Adams and Foley in 1953 studied 60 patients with hepatic coma and documented classically the neuropsychiatric features of this condition.[1] They emphasized confusion and inappropriate behavior, which preceded coma, muscular rigidity, hyperreflexia, "flapping tremor" of the arms and a characteristic electroencephalogram.

Clinical Features

The syndrome of hepatic coma is characterized by various mental and neurological manifestations, which may be fluctuating, regressive, progressive, gradual or rapid. Usually, the stages of hepatic coma are classified into impending hepatic coma and deep coma. The mental characteristics of impending hepatic coma are restlessness, poor judgment, euphoria, confusion, depression, lethargy, noisiness, inappropriate behavior, agitation, disorientation, hallucinations and paranoid ideas. The neurological signs may be episodes of muscular rigidity or flaccidity, diminished or hyperactive reflexes, absence of corneal reflexes, positive Babinski and Hoffman signs, ankle clonus, grasping and sucking reflexes, response to painful stimuli by shouting, crying or moaning.

A "flapping tremor" practically implies hepatic coma, though it may be found infrequently in uremia, hypokaliemia, ammonia intoxication or polycythemia vera with congestive heart failure. This tremor may be observed in the extremities and facial muscles of the patient with arms outstretched and fingers spread, at which time rapid, irregular extension-flexion movements at the wrist, elbow or shoulder occur. Fetor hepaticus and the "flapping tremor" are the two most ominous clinical features in patients with severe hepatic insufficiency.

Another important feature of hepatic coma is the invariably abnormal, though nonspecific electroencephalographic pattern.[2] This consists

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†From the Department of Medicine (Gastroenterology) Vanderbilt University School of Medicine, Nashville, Tennessee, and Section of Medicine (Gastroenterology) Western Baptist and Lourdes Hospitals, Paducah, Kentucky.

of various stages as the depth of hepatic coma increases: (1) theta stage with diffuse waves of a frequency of 4 to 7 second; (2) triphasic stage, characterized by diffuse, bilaterally synchronous, triphasic waves whose maximal deflection is surface positive; and (3) delta stage with random arrhythmic waves and little bilateral synchrony. No correlation exists between the concentration of blood ammonia and abnormal electroencephalographic pattern in patients with hepatic coma. The theta stage occurs during impending hepatic coma and also is observed during epileptic seizures, whereas the triphasic and delta stages are present during hepatic coma.

Several Courses

The patient in hepatic coma may recover spontaneously, have stages of remissions and relapses, remain in coma for days or several weeks, or unalterably progress slowly or rapidly to death. Once coma supervenes, the clinical picture is that of a deep, quiet sleep, fever, dehydration, slow, deep, prolonged respirations, rapid, irregular pulse and normal arterial blood and cerebrospinal fluid pressures.[3] The arterial blood pressure, however, may fall and may produce further hepatic, cerebral and renal anoxia. The ill-named hepato-renal syndrome may result as a consequence of the aforementioned renal lesion associated with hepatic disease or arterial hypotension and may manifest as oliguria, anuria and azotemia.

Resolution of hepatic coma may occur, but usually death occurs suddenly or unexpectedly as the result of shock, renal insufficiency, fever, electrolyte abnormalities, gastrointestinal hemorrhage, paralytic ileus, broncho-pneumonia, bacteremia, abdominal paracentesis or intoxication from sedatives, narcotics, parenteral protein or diuretic agents. It has been observed that the longer hepatic coma persists, the poorer the prognosis.

Predisposing and Precipitating Factors

Hepatic coma may occur spontaneously or be the result of or associated with various predisposing or complicating factors in patients with different types of hepatic disease. These diseases are principally cirrhosis, hepatitis, or metastatic invasion of the liver, and, less commonly, cholestatic hepatic disease, abscess, fatty infiltration of the liver and various infiltrative or granulomatous hepatic diseases. The conditions or agents which can precipitate hepatic coma in patients with cirrhosis include the following: alcoholism; gastrointestinal hemorrhage; infections; neoplasms including cerebral metastasis; drugs, such as hypnotics, sedatives, narcotics, ammonium salts or ammonium-containing cation-exchange resins, diuretic agents, methionine, sulfonamides; abdominal paracentesis; fluid and electrolyte imbalance; surgical operations; anesthesia; fever; diets containing protein or intravenous protein hydrolysate; portacaval shunt; transfusions of blood and congestive heart failure.[4]

It is apparent that stress of any type or an iatrogenic component may induce or contribute to the production of hepatic coma, suggesting the abnormally sensitive metabolic relationship between the liver and brain in patients with parenchymal hepatic disease.

Liver a Major Site

It has been observed that when hepatic coma ensues, its occurrence is spontaneous in half of the patients with cirrhosis. Massive gastrointestinal hemorrhage, infection, abdominal paracentesis, anesthesia or surgical operation, for example, precipitate coma in other patients, further producing hepatocellular necrosis by diminishing the supply of oxygen and nutrient to the already damaged liver. Bacterial and viral infections are common precipitating factors in the production of hepatic coma. This may be due to fever which is known to produce hepatocellular necrosis, reduction of blood and oxygen to the liver, or possibly bacterial or toxic products reaching the liver via the portal vein. The liver is known to be a major site for the removal of bacteria, though little is known as to what toxic effects, if any, bacteria have upon the liver.

Electrolyte and water deficits and injudicious or unnecessary diuresis or abdominal paracentesis are known to contribute to or produce hepatic coma. In particular, hyponatremia and hypochloremia resulting from overhydration, sodium-restricted diets, drug-induced diuresis, or abdominal paracentesis may manifest itself in the low-sodium syndrome, in which apathy, drowsiness, confusion, psychosis, coma, weak-

ness, cramps and twitchings are central nervous and muscular features.

Biochemical abnormalities, such as hypokaliemia, low-serum magnesium, hypophosphatemia and respiratory alkalosis, may play a minor contributory role in the pathogenesis of hepatic coma; however, correlation between these biochemical abnormalities and hepatic coma is lacking. (Figure 1) Acetozolamide and

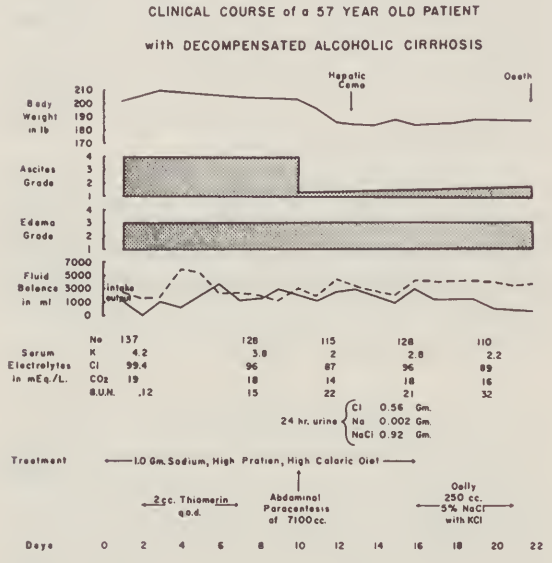


Figure 1

chlorothiazide, which are effective diuretic agents in patients with hepatic disease, have been demonstrated to contribute to hepatic coma. Diuresis with mercurials is known to produce depressed concentrations of sodium, potassium and chloride, in particular, and also metabolic alkalosis. For this reason, the concurrent administration of calcium and potassium chloride during mercurial diuresis is recommended.

Pathophysiological Manifestations

Hepatic coma has been attributed to elevation of pyruvic, lactic and amino acids.[3,5] Impaired carbohydrate intermediary metabolism, particularly the formation of cocarboxylate from thiamine, may explain high lactic and pyruvic acid levels. Cerebral anoxia, decreased cerebral oxygen consumption and respiratory alkalosis have been suggested as contributing to the metabolic defect in patients with hepatic coma. However, none of these metabolic abnormalities satisfactorily explains the pathogenesis of hepatic coma. The main possible exception is the role of abnormal ammonia metabolism. The patient with hepatic insufficiency is not unlike one with myocardial disease in that the reduction of blood supply and oxygen perpetuates cellular necrosis.

Ammonia Metabolism

In the past 15 years there has been considerable investigation of protein, enterogenous nitrogenous substances and ammonia in the pathogenesis of hepatic coma. Bollman and Mann found increased ammonia and decreased urea in the blood of hepatectomized animals.[6] Bilateral nephrectomy, on the other hand, performed simultaneously with a hepatectomy did not alter significantly the concentration of blood urea.

These experiments demonstrated that the liver was capable of deamination and that urea was formed in the liver from ammonia. Following hepatectomy, Eck fistula or experimental hepatic injury, protein alimentation was demonstrated to be lethal, a phenomenon called "meat intoxication." Elevated ammonia concentration was found in the blood. Ammonia is produced in the intestinal tract by urea-splitting bacteria (urease) and is absorbed into the portal vein but is not metabolized enzymatically to urea in hepatic injury.

Similarly, it has been demonstrated in humans with hepatic diseases and natural or surgical portacaval shunts that the administration of protein, urea or ammonium salts in one form or another induces a syndrome resembling hepatic coma in which there exist high levels of blood ammonia.[7-10] Elevated blood ammonia and alpha-keto glutarate levels have also been demonstrated in patients with cirrhosis in hepatic coma and occasionally in cirrhotics without hepatic coma. Disturbed intermediary metabolism involving the Kreb's cycle, the vitamin B-complexes, and failure of the diseased liver to form necessary metabolic products has also been considered in explaining hepatic coma.

However, the correlation between the concentration of ammonia in the blood and the mental state of patients with cirrhosis is inconsistent and, as a consequence, the need for some other biochemical explanation of hepatic coma

besides ammonia intoxication is readily apparent. The correlation is better in patients with hepatitis, particularly children, and may be indicative of the tremendous reserve capacity of urea synthesis. Impaired hepatic function and the association of collateral portal venous circulation, which diverts portal blood containing a high concentration of ammonia and nitrogenous substances into the systemic circulation, have been considered important in the pathogenesis of hepatic coma.[11,12] This implies the existence of an endogenous or spontaneous type of hepatic coma, about which little is known. It appears to be related to hepatocellular necrosis rather than directly to elevated blood ammonia values.

The role of glutamine metabolism has been studied in patients with hepatic coma. Glutamine, formed in the liver enzymatically with the combination of glutamic acid and ammonia, has been demonstrated at times to be increased in the brain, blood and cerebrospinal fluid in experimental hepatectomized animals and in humans with hepatic coma.[13] Diverse correlation has been demonstrated between elevated arterial ammonia and pyruvate levels and cerebral oxygen utilization.

Blood Ammonia Levels

Bessman has stated that blood ammonia levels are unreliable prognostically in hepatic coma.[14] Both the brain and skeletal muscles metabolize ammonia. Enterogenous toxins other than ammonia may induce hepatic coma, and it is important to consider what chemical is absent rather than excessive in the brain of a patient in hepatic coma. Nevertheless, the administration of glutamic acid therapeutically to neutralize the elevated blood ammonia concentration ameliorates hepatic coma.

Bessman has studied the role of serotonin or 5-dihydrotryptophane, a precursor of serotonin. Though not synthesized by the diseased liver, treatment of hepatic coma with this substance alters the abnormal electroencephalographic pattern.[14] A defective metabolism of serotonin has been considered to be present in patients in hepatic coma, particularly if the monoamine oxidase activity of the liver or brain was inhibited. Generally, there is sound circumstantial evidence that serotonin is important in cerebral function. A primary disturbance in 5-hydroxyindoleacetic acid has been demonstrated in patients with cirrhosis with and without hepatic coma. Electroencephalographic improvement resulted after parenteral administration of small doses of this metabolite.

Pathophysiology Of Hepatic Coma

Information derived from necropsies of patients who died from hepatic coma discloses no specific pathological lesion in any of the organs of the body.[4,15] This would appear to indicate that hepatic coma results from a metabolic abnormality rather than from a specific lesion in the liver, brain or kidney. The morphological manifestations of any type of cirrhosis in a patient who has died from hepatic coma do not differ from those demonstrated when cirrhosis is latent or associated with ascites, portal hypertension or mild hepatic insufficiency. Histologically "active" cirrhosis, determined particularly by the presence of hepatocellular necrosis, fatty infiltration, alcoholic-hyaline (Mallory) bodies in the hepatic cells, stasis of bile and infiltration with polymorphonuclear leukocytes, may be present in the liver regardless of hepatic coma.

The brain and central nervous system have been studied in patients with cirrhosis who have died in hepatic coma and no specific lesion has been demonstrated conclusively. Perivascular demyelination, endothelial proliferation, increased number and size of protoplasmic astrocytes, meningeal edema, focal hemorrhages and congestion of blood vessels are nonspecific neuropathological findings in the brain.

Renal Findings

No specific lesion has been noted in the kidney in patients who have died in hepatic coma. Intercapillary glomerulonephritis, chronic passive congestion, "lower-nephron nephrosis," bile nephrosis and acute glomerulonephritis may be pertinent renal findings.

There are no laboratory tests of hepatic function that are diagnostic or distinguish impending from deep hepatic coma. No consistent differences in the conventional hepatic function tests at present occur in patients with hepatic disease even before and during hepatic coma. Polymorphonuclear leukocytosis is often observed and may reflect marked hepatocellular

necrosis. An increase in the blood urea nitrogen is a common biochemical finding and may be related to renal insufficiency, gastrointestinal bleeding and assimilation of protein. Occasionally, the blood urea is abnormally low, indicating impaired deamination by the diseased liver. The level of blood urea nitrogen may vary in hepatic coma depending particularly on hepatic and renal insufficiency. It has been demonstrated that the level of blood ammonia is low in renal insufficiency and, therefore, is a more reliable index than the blood urea nitrogen in hepatic coma, which is elevated with renal insufficiency. Concentrations of alpha-amino nitrogen, phenol, lactic acid, pyruvic acid, ammonia and glutamine in the blood may be elevated in patients with hepatic coma but do not aid in diagnosis.

Hypoglycemia occurs infrequently in hepatic coma in humans and could produce mental aberration. It is considered a pathogenetic factor, however, in hepatic coma in animals as the result of hepatectomy or hepatic necrosis. Decreased levels of fasting blood sugar may be observed following a portacaval shunt. In this circumstance, insulin in the portal blood stream is shunted from the liver and is not metabolized by hepatic insulinase. Decreased blood levels of cholesterol, phospholipids and cholesterol esters, and, particularly, low serum cholinesterase and elevated values of serum transaminase (SGO-T and SGP-T) in the blood are significant biochemical findings at the time of shunt surgery or evaluating the prognosis of hepatic coma. (Figure 2)

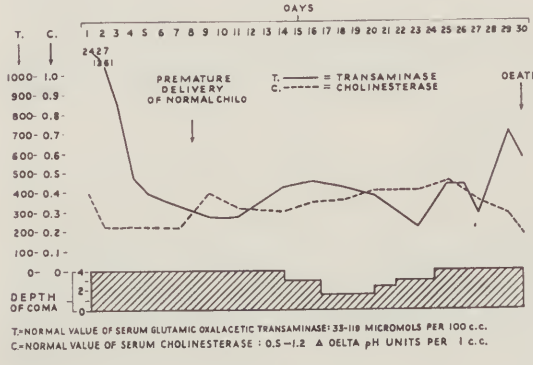


Figure 2

Abnormalities in acid-base metabolism and electrolyte and water imbalance are particularly common in patients in hepatic coma. Their therapeutic amelioration is at times difficult and frequently perpetuates a vicious cycle of various types of metabolic deficits. Hyponatremia, hypochloremia and hypokaliemia are common biochemical abnormalities, which may be related to hepatocellular damage, sodium restricted diets, ascites, abdominal paracentesis, inanition, vomiting, diarrhea, intestinal intubation, suction, diuresis, intravenous administration of isotonic or hypertonic dextrose, overhydration or use of cation-exchange resins. Hyperkaliemia may be present and is usually due to overzealous treatment with potassium salts or to renal insufficiency. Deficits in the concentrations of calcium, phosphorus and magnesium are other biochemical abnormalities observed even if renal function is increased.

Decreased carbon dioxide may be present early in hepatic coma. Its cause is obscure but may be related to ammonia intoxication, hypokaliemia or decreased cerebral oxygen consumption. Eventually, metabolic acidosis due to renal insufficiency or respiratory acidosis due to respiratory defect may supervene. It is apparent that there is no consistent alteration in the serum electrolytes and pH in patients in hepatic coma and frequently they are induced iatrogenically.

Pathophysiological Considerations

The therapeutic management of hepatic coma involves the most complete, careful and expedient observation and cooperation possible between attending physicians, nurses and laboratory personnel in a manner very similar to the treatment of patients with massive gastrointestinal hemorrhage, diabetic coma, adrenal cortical insufficiency or drug intoxications. Because of the high mortality observed in patients with hepatic coma, it behooves the attending medical personnel to facilitate rapidly the exact therapeutic measures.

It is necessary to maintain an accurate record of body temperature, pulse, arterial blood pressure, respiration, fluid intake and output, bowel movements, diet and therapeutic agents together with descriptions of the neuropsychiatric behavior of patients in hepatic coma. It has been found advisable to maintain a chart of the results of various laboratory data listing hepatic function tests, electrolyte values of the blood and urine, urinalysis, complete blood count, blood urea nitrogen or nonprotein nitrogen and

fluid intake and output in correct daily, chronological arrangement. It may be necessary to insert an indwelling urinary catheter in these patients in order to estimate accurately the urinary output. In this situation, it is recommended that urinary antisepsis be maintained by antobiotics and by irrigations of the catheter with potassium permanganate or some other topical antiseptic agent.

Complete bedrest is advisable in patients in all stages of hepatic coma. The physician, however, should use his discretion in allowing patients in impending hepatic coma ambulatory privileges to prevent muscular hypotonicity, osteoporosis, joint contractures, decubitus ulcers, venous thrombosis and to maintain the best possible appetite and mental alertness. Siderails are advisable in all these cases, particularly at night. Frequent tapwater enemas, instead of hypertonic or saline types, are advisable in treating constipation or removing toxic material from the colon. Hyperthermia is best treated by alcohol-sponge baths, icewater enemas, ice-bags or the application of cold packs to the body. Oral and ocular hygiene measures should be resorted to in the form of mouth antiseptics, glycerine applied to the lips and ophthalmic boric acid drops.

Intercurrent Infections

Intercurrent infections should be identified by culture and its sensitivity to various antibiotics demonstrated. In any event, providing the patient is not allergic to antibiotics, the administration of depot procaine pencillin with dihydrostreptomycin or intramuscular tetracycline or one of the broad-spectrum antibiotics is recommended in the routine management of patients in hepatic coma because of their susceptibility to infection.

Oxygen should be prescribed in the amount of 8 liters per hour by tent to lessen the possibility of cerebral or hepatic hypoxia. Ascites interferes with respiration and reduces the vital capacity of the lungs. Oxygen should be administered carefully to prevent "oxygen poisoning" in patients with respiratory acidosis, particularly those with pulmonary emphysema. An open respiratory air-way should be maintained in comatose patients, in whom collections of nasopharyngeal and bronchial secretions may obstruct the upper respiratory system. Intestinal decompression and suction by intestinal intubation are advisable in the management of paralytic ileus, which occurs not uncommonly in patients in hepatic coma.

Arterial blood pressure should be maintained by the careful administration of transfusions of blood or plasma-expanding agents or Vasoxyl®, Levophed® or Neo-synephrine®. It is apparent that the overzealous use of transfusions of blood has inherent dangers in these patients, particularly in their content of protein and that the abuse of vasoconstrictor drugs to maintain intractable arterial hypotension can induce hepatic and renal anoxia.

Drugs In Therapy

The intramuscular administration of an iron-dextran complex (Imferon®) should be considered in the treatment of iron-deficiency anemia in patients with hepatic coma. Sedative and hypnotic drugs are necessary to control restlessness, euphoria, abnormal behavior and convulsive seizures and analgesics and narcotics may be used to diminish abdominal pain. It is advisable to discriminate when employing these drugs in any patient with hepatic disease. Opiates, paraldehyde, methodon, chloryl hydrate, and most barbiturates are highly dangerous and should never be employed therapeutically in patients with marked hepatic insufficiency, mainly because of their depressive respiratory effects, perpetuation of their effects and persistence of the drug in the blood due to impairment of detoxification and excretion by the injured liver.

Sedation a Problem

The selection of a proper sedative, analgesic or hypnotic agent in the management of a patient with hepatic insufficiency presents a problem. Generally, phenobarbital or barbital is advocated because they are excreted to a great extent by the kidney. Demerol®, if prescribed discriminately, is considered a safe analgesic agent in this condition. Intramuscular chloropromazine or perphenazine in small doses appears to be safe in the management of hepatic coma. The injurious effect of anesthetic agents upon the diseased liver should not be overlooked. Chloroform has been shown to be hepatotoxic, and sodium pentothal is highly inadvisable in the presence of hepatic injury.

Spinal anesthesia is probably the safest method of anesthesia and ether-nitrous oxide or cyclopropane are reasonably safe anesthetic agents to be employed during an operative procedure on patients with hepatic disease provided adequate oxygen is administered and arterial blood pressure maintained.

Diet

Strict attention should be paid to the selection of a proper diet in the management of patients in hepatic coma. If possible, it is advisable to prescribe a diet containing from 1,800 to 2,400 calories, 20 to 40 grams of protein, 300 to 400 grams of carbohydrate and sufficient fat for palatability. This may be accomplished by oral or tube feedings and may be supplemented by the intravenous administration of 10 per cent glucose in water.

The intake of protein may be gradually increased to 70 grams daily only if recovery is apparent. If relapse occurs, absolute restriction of dietary protein is necessary. This may be accomplished by tube or intravenous administration of hypertonic glucose and fat emulsion. These may provoke vomiting, diarrhea and paralytic ileus with further embarrassment to the already present electrolyte and water deficit; on the other hand, hypertonic glucose administered intravenously and usually containing electrolytes and multivitamins may induce thrombophlebitis, pyogenic reactions, cellulitis and water-logging. Three thousand cubic centimeters of 10 per cent glucose administered daily will afford the patient 1,200 calories and an additional 1,000 calories may be supplied by 50 per cent glucose, grape juice or peanut oil introduced by gastric lavage.

Delicate Therapeutic Balance

The physician encounters a delicate therapeutic balance in the administration of protein in severe hepatic insufficiency. Inadequate amounts of protein retard hepatocellular healing, whereas excessive amounts may precipitate hepatic coma. Therefore, the dietary management of these patients is highly individualized and, at best, it is wise to administer the patient at least 1 gram of protein per kilogram of body weight as soon as possible.

The physician treating patients with chronic liver disease is faced with the therapeutic problem of "calories vs protein." Protein should be eliminated from the diets of patients with hepatic coma for the shortest time possible. Institutionalized demented patients have been noted to have cirrhosis in which restriction of dietary protein was ameliorative.[3] The administration of dietary protein to the cirrhotic patient also becomes a problem when anorexia, malnutrition, need for restriction of sodium and gastrointestinal symptoms such as nausea, vomiting, intolerance to fatty foods, constipation, diarrhea and abdominal distention are present.

Systematic management of these problems, parenteral hyperalimentation and close cooperation with the dietician, who is often able to select appetizing and colorful diets, may be rewarding. Occasionally, salt-poor serum albumin in the amount of 25 to 50 grams per day may benefit patients in hepatic coma, particularly when marked hypoalbuminemia, ascites or edema is present; usually it is ineffective, not without inherent danger and costly.

Fluids and Vitamins

One of the most highly respected types of therapy employed in patients with hepatic coma is the parenteral administration of glucose and vitamins. Frequently, the benefit derived from this is dramatic in patients with impending hepatic coma, or early in the course of deep hepatic coma. There have been enthusiastic reports of the results of continuous intravenous administration of 3,000 to 4,000 cc. of 10 per cent glucose containing 50 to 100 mg. of thiamine and 250 to 500 mg. of nicotinic acid. Summerskill has employed hypertonic Dexin®, a partially hydrolyzed starch, by gastric tube or intravenously, using a polyethylene catheter.[10] This substance (1 gram equivalent to 4 calories) may satisfy the recommended intake of 2,000 calories daily without overhydration.

Fat emulsions administered intravenously largely supply the caloric requirements in hepatic coma. Supplying 1,200 cc. of Lipomul®, which contains 15 per cent cottonseed oil and 4 per cent glucose, affords 1,800 calories. The solution can be infused for reasonable periods of time without causing any phlebitis but may induce an occasional case of fever, nausea, anorexia, vomiting, dizziness and chills. Fat emulsions tend to produce abnormalities in hepatic function tests which tend to return to the preinfusion state after emulsions are with-

drawn. Abuse of intravenous administration of glucose may be demonstrated in electrolytic deficits, particularly hyponatremia, hypokaliemia, overhydration, pulmonary edema and even precipitate hepatic coma and death.

It is customary to prescribe unreasonably large doses of vitamins parenterally to patients in hepatic coma, most of which are excreted soon in the urine. There is no actual benefit to those patients, and their costliness becomes readily apparent. The fact that the majority of these patients have no evidence of avitaminosis suggests that large therapeutic doses of vitamins are unreasonable. Actually, the dosage contained in two standard therapeutic vitamin preparations in addition to no more than 5 mg. of vitamin K and possibly 1 mcg. of vitamin B_{12} should be considered adequate.

Adjunctive Therapies

Adjunctive therapies of hepatic coma are antibiotics, adrenocorticotropic hormone, adrenal glucosteroids, glutamic acid and arginine. The broad-spectrum antibiotics have been employed therapeutically because of their beneficial use in the management of acute fulminant hepatitis, protection against infection and reduction of intestinal bacteria in an effort to decrease the amount of enterogenous ammonia.[16,17] The daily administration of a broad-spectrum antibiotic such as neomycin from 2 to 4 grams orally, intramuscularly or by nasogastric tube will reduce the intestinal bacterial flora that produce ammonia, thereby lowering the concentration of ammonia in the blood. However, decreased body weight, positive nitrogen balance, increased urinary nitrogen and possibly increased fecal nitrogen may result.

The dangers of broad-spectrum antibiotics in the treatment of hepatic coma are demonstrated by therapeutic failure, hepatic toxicity, negative nitrogen balance, fatty infiltration of the liver, avitaminosis K, pseudomembranous enterocolitis, gastrointestinal hemorrhage and vomiting.

The use of adrenocorticotropic hormone or corticosteroids in the management of patients in hepatic coma has been unpredictable.[4,18] In fact, steroid therapy may render masked clinical improvement, reduction in hyperbilirubinemia and no regeneration of hepatocellular necrosis. Massive doses of cortisone, 250 mg. every 6 hours, produce temporary alertness and activity, and improve oral nourishment in patients in hepatic coma. The use of these hormones usually is a "desperation measure" and may induce serious complications, such as retention of fluid, acute pancreatitis, gastrointestinal hemorrhage, venous thrombosis and electrolyte imbalance and masked infection.

Glutamic and Thioctic Acid Therapy

Therapeutic results of intravenous administration of large doses of glutamic acid or sodium glutamate, as a specific treatment of hepatic coma, have been contradictory. Glutamic acid therapy has been employed in these cases because the mechanism of hepatic coma has been found to decrease the high content of ammonia in the blood in patients with hepatic coma due to ammonium chloride, proteins or following a portacaval shunt.

The fact that the mechanism of hepatic coma in patients with cirrhosis has not been proved to be ammonia intoxication has made many skeptical of this type of therapy. It has been concluded that glutamic acid therapy is specific for cases of exogenous or ammoniagenic hepatic coma. That the therapeutic results are unimpressive in endogenous hepatic coma may be seen in poor results recorded in 200 cases by McDermott.[9] Bessman regards glutamic acid therapy in this condition as a binding rather than specific form of treatment.[14]

Intravenous Administration

The drug is administered intravenously in average doses of 40 grams daily and, when prescribed as the sodium salt, produces marked hypernatremia. Some observers have considered doses up to 200 or more grams administered within 36 to 48 hours to be more effective.

The occasional dramatic response to glutamic acid therapy probably merits its use until a better agent is discovered. Generally, glutamic acid therapy has been found to be more efficacious in hepatic coma resulting from or following the administration of dietary protein or ammonium salts, surgical shunt procedures, infections, or gastrointestinal hemorrhage, so-called complicated hepatic coma. On the other hand, in hepatic coma without these complications but in which there is progressive or mark-

ed hepatocellular damage, this therapy appears useless.

Thioctic acid has been employed in the treatment of hepatic coma with unimpressive results. Thioctic acid, lipoic acid or the pyruvate oxidation factor, a biocatalyst, has an essential role in the oxidation of alphaketo acids and in the transference of pyruvic acid into the Kreb's cycle. L-arginine, also active in the Kreb's metabolic cycle, has been demonstrated to reduce blood ammonia levels in hepatic coma. The intravenous administration consists of 25 grams of arginine hydrochloride with 50 grams of glucose in 500 cc. of water, or one of the newer commercial preparations of the glutamic acid salt of arginine every six hours. Acidosis may be produced by arginine, and hypernatremia and alkalosis from sodium glutamate.

The mechanism by which arginine produces lowering of the blood ammonia is different from that of glutamic acid which is related to the ornithine cycle. It would seem that, in evaluating the therapeutic results of glutamic acid, corticosteroids, arginine and thioctic acid, these must be considered in light of proper therapeutic controls. One should be cautioned against an overzealous therapeutic attitude, because glucose, fluids, oxygen, antibiotics and transfusions of blood are often not considered when evaluating the results of newer types of therapy in hepatic coma.

Summary

1. Hepatic coma or advanced hepatic insufficiency represents a specific end-organ failure. Its genesis is obscure. As a result, treatment of hepatic coma is generally unsatisfactory.

2. The clinical management of hepatic coma requires meticulous professional attention, protein withdrawal, intestinal antisepsis, hepatocellular repair and knowledge of portasystemic shunts.

3. Further investigation of the intermediary metabolism of the liver is necessary to understand the physiological problem of hepatic coma.

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Gouty Arthritis: A Clinical Study*

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This review of 45 proven cases of gout emphasizes the frequency of multiple joint involvement and vascular complications. Various causes of improper diagnoses are pointed out

FOR centuries the victims of gout have been the subject of lampoons and caricatures. We now know that they should rather by the objects of great concern, for the disease is painful, disabling and is accompanied by complications that impair health and shorten life.

Gout is an ancient disease, well known to physicians of ancient Greece and Rome. The alkaloid of the autumn crocus, colchicine, was introduced into therapy by Alexander of Tralles about 500 A.D. The presence of uric acid in a kidney stone was first demonstrated in 1776 by Schell, and in 1797 Wallaston found uric acid in gouty tophi. In 1848 Garred discovered that patients with gout have elevated uric acid levels in their blood. Fifty-six years ago (in 1903) Folin introduced an accurate quantitative measure of the blood uric acid.

Ancient as the disease is, its etiology remains unknown. For some reason, people and families with gout have a metabolic error characterized by an increased production of uric acid from various precursors. Thus all gouty subjects have an abnormally large uric acid content in their bodies. Part of this uric acid is in solution and forms the "miscible pool." The remainder of the uric acid is "immiscible" and consists of deposits of urate crystals in various body tissues.

Pathology

The foreign body reaction to uric acid crystals is the essential feature of the pathology of gout. At first the inflammation is reversible and for a time there may be no joint destruction. Even with repeated acute attacks there may be no pathological changes except for the finding of urate crystals in the articular cartilages. However, as times goes on and the disease becomes chronic the joints become enlarged and grossly deformed by calcareous deposits and bone destruction.

No joint is exempt, although there is a predilection for those of the lower extremities. Deposits of urate crystals may form gouty "tophi" in other tissues such as the helix or antihelix of the ear, the olecranon or patella bursa, the tendons of the distal portions of the extremities, the skin of the palms and soles, or the cornea of the eye.

The urates may also become deposited in the kidneys and by their presence produce an inflammatory, and later a destructive reaction. The kidneys eventually become reduced in size and, to add insult to injury, the tubules may become blocked by urate concretions and subsequently abscesses may form and pylonephritis may occur. These changes combine to produce vascular sclerosis and clinical hypertension with all its implications.

Clinical Picture

Adults of all races are subject to gout. The typical acute attack begins at night. The pain is excruciating. The involved joint becomes red, hot, swollen and tender. Joint effusions may occur. The appearance mimics a cellulitis

*Presented at Fourth Annual Fall Clinical Conference, Lexington Clinic, Lexington, Kentucky, October 21 and 22, 1959.

†Division of Medicine, Lexington Clinic.

and there may actually be a "chemical" lymphangitis. When the joints of lower extremities are involved, the pain is severe enough to prevent weight bearing. A low grade fever and a moderate elevation of the erythrocyte sedimentation rate sometimes are found.

Even if untreated, the acute attack subsides within a few days. As the years go by, the attacks tend to occur closer together and finally the disease becomes chronic. It is not unusual for the joint involvement to be migratory in type.

We have found in the Lexington Clinic cases that an average of three years elapses between the onset of the disease and its correct diagnosis. This rather startling fact was noted in a recent review of 45 proven cases of gout which have been seen at the Lexington Clinic over a 10-year period.

TABLE I
Joints Involved
In 45 Proven Cases Of Gout

MTP	37	Elbow alone	1
Foot	11	Shoulder	2
Ankle	12	Elbow	11
Knee	10	Wrist	3
Hip	2	Hand and Fingers	5
Spine	2	Wrist alone	1
Ankle alone	11	Wrist & Knee	1
Foot alone	1	Foot, Ankle, Hip	1
Knee alone	1		

Of these 45 patients, 41, or 91 per cent, were males, and four, or nine per cent, were females. Forty-one were white and four colored. The average age at the onset of the disease was 45.8 years. The youngest patient in the group had his first attack at the age of 22 and the oldest at 77 years of age.

A positive family history of gout was obtained in only two patients.

In this group of patients the lesions were confined to one joint in only 21 patients or 46 per cent, and involved multiple joints in 24 (54 per cent). The most common site of involvement was the first metatarsal-phalangeal joint which was involved in 37 patients or 82 per cent of the whole group. It should be pointed out that in eight patients (18 per cent) this joint was never affected.

The relative frequency of involvement of the various joints is indicated in Table 1.

Precipitating causes of the acute attack were demonstrated by five patients. In one the attack occurred after administration of chlorothiazide. In two patients the attacks were precipitated by surgical procedures, in one it followed an ankle sprain and in one other followed exposure to extreme cold.

Many of these patients had been treated for "arthritis," "neuritis," "infections," et cetera, before admission to the Clinic. One man had had innumerable attacks over a 10-year period and had received at least 80 penicillin injections without effect. Another had had all of his teeth extracted without relief of symptoms.

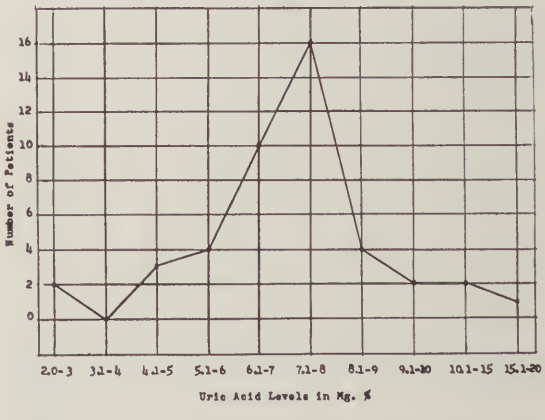
Complications

Serious vascular complications occurred in 15 patients (35 per cent). Two patients had gouty nephritis and died in uremia. There were seven patients who had associated hypertension and six others who had coronary heart disease. Two others had renal stones. About 50 per cent of the patients were obese.

Laboratory Findings

The average initial fasting serum uric acid level of the 45 patients was 7.61 mg. per cent. The distribution of these levels is listed in Table II.

TABLE II
Blood Uric Acid Levels
In 45 Cases Of Gout



It is to be noted that in five patients the uric acid levels were 5 mg. per cent or less. However, four of these patients had been receiving either steroids or phenylbutisone when first seen here. Both of these agents are capable of reducing the serum uric acid levels. The fifth patient had persistently normal uric acid levels, but the correct diagnosis was established by a biopsy of an olecranon bursa. He ex-

perienced marked improvement after institution of specific treatment for gout.

Comment

The diagnosis of gout may be difficult. Of the 45 patients studied here, 21 had been seen by other physicians and the diagnosis had not been established. Practically all of these 21, it should be stated, were examples of multiple joint involvement in a more or less chronic form. In our opinion, if the frequency of multiple joint involvement is kept in mind, the correct diagnosis can almost always be made clinically. The salient diagnostic features are the suddeness of the onset of the pain, the severity of the pain, and the disabling character of the pain, and tenderness. The tendency of the pain to be most severe at night can be a diagnostic clue.

A fasting serum uric acid level of over 6 mg. per cent gives cause for suspicion, particularly if the blood urea nitrogen content is within normal limits. A word of caution deserves repetition; large doses of salicylates, steroids, and phenylbutisone may artificially depress the serum uric acid level. On the other hand, chlorothiazide or small doses of salicylates may artificially increase the uric acid level. We have encountered examples of false positive diagnoses of gout which have stemmed from this artificial situation.

The diagnosis of gout can be confirmed by needle biopsy of a tophus or, if necessary, of the joint. Uric acid crystals can be demonstrated from these sources if the proper technique is used.

Roentgenograms of the involved joints can be useful in making the diagnosis at times. Other causes of bone and joint pathology can be excluded by roentgenology, but in none of our cases was the diagnosis conclusively established by our radiologist.

A final diagnostic test can be the almost universally dramatic improvement produced by administration of colchicine.

Summary

A review of the clinical diagnostic features of gout has been presented. The frequency of multiple joint involvement has been emphasized by the results of a study of 45 cases of gout seen at the Lexington Clinic during the past 10-year period.

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Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

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Going Downhill - A Lethal Journey

Israel Diamond, M.D.*

Louisville, Ky.

The great majority of individuals do not die in acute, dramatic fashion. The coup de grace is usually administered by a relatively minor infection

Our objectives in medicine are rightly directed to the preservation of life, but this orientation does not preclude the possibility of advances in our knowledge to be gained from a study of death. It is surprising, although understandable, how little has been written about the mechanism of death. The majority of textbooks of pathology and physiology do not carry a reference to the subject in their indices. The monographs in forensic medicine deal extensively with death from the standpoint of etiology-homicide, accident, suicide or natural causes but, even in these works, little or no attention is paid to the mechanism.

Acute Deaths

In the acute or dramatic deaths, our professional knowledge and understanding are closely approximated by the layman. Everyone understands that when heart action ceases irreversibly, death occurs. It is also apparent that irreversible anoxia causes death; consequently we have no difficulty in understanding why an individual dies from electrocution, strangulation, drowning, decapitation, exsanguination, myocardial infarction and massive pulmonary embolism. In cranial injuries, brain hemorrhage and edema we feel fairly secure in our explanation of interference with blood supply to the so-called vital centers.

The classic teaching has long been that interference with the vaso-motor and the respiratory center leads to death by mechanisms that usually imply a more or less abrupt cessation of heart and lung activity. Death from surgical shock is usually attributed to pooling of blood in the splanchnic circulation, with resultant decreased cardiac out-put and consequent anoxia to the vital centers. Such an explanation may or may not be correct. In any case, unquestioning acceptance blocks any possible advance in understanding.

Death by Attrition

The great majority of individuals do not die in acute, dramatic fashion. Rather, they suffer from apparent disease for variable periods of time, sometimes quite long, and ultimately succumb. We have no difficulty in accepting pneumonias, heart-failures and cancers as causes of death; but we also have no difficulty in accepting these conditions as compatible with continued existence. We are equally familiar with the fact that most serious chronic disease brings the patient close to death, but does not actually kill him. The coup de grace is usually administered by a relatively minor infection or similar incident.

While our assumptions regarding the role of bronchopneumonia as a cause of death in a long-standing case of carcinoma may be correct, it hardly provides, in itself, an explanation. We tend to explain such phenomena with words rather than data. We usually refer to these patients as having "gone down-hill," or having "petered out." When the course has been rapid we may hear that metaphorical treat, "the bottom dropped out."

From the Department of Pathology of the Children's Hospital, Louisville, Kentucky, and the University of Louisville School of Medicine.

Medical sophistication may change the phrases without altering content—"there has been an attrition of resistance, vitality, organ function or metabolic processes, to a level incapable of sustaining life," or "there has been a disturbance in entropy; the individual can no longer balance his energy loss," or "his enzyme systems have been interfered with sufficiently to no longer maintain life." Just as frequently, death is attributed to the intensity or aggressiveness of the disease. Such statements may or may not be true or partially true, but they hardly constitute valid explanations. They probably approach the validity of the layman's metaphysical explanations.

The same is true for teleological explanations such as, "all life is limited;" "there can be no life without death" and "all organisms begin to die at birth." They hardly begin to explain or help us understand why the individual managed to live at all with his disease.

Veno-pressor Failure

To my knowledge, the only serious consideration regarding the mechanism of the "down-hill" journey most of us take was given by Yandell Henderson[1] over a period of 40 years of investigation, and summarized in 1943. In this brilliant and remarkably concise paper, Henderson presents a mechanism of death which may have wide application and may explain death in many individuals who go abruptly "down-hill," as well as those making the journey in more leisurely fashion. Henderson presents a number of simple propositions, most of which constitute accepted physiological dicta:

1. The cardiac out-put cannot exceed the cardiac in-put.
2. Progressive decrease in cardiac output leads to cardiac arrest.
3. The major factor and force in returning blood from the capillary bed to the heart is the pumping and milking action by muscles upon veins—the veno-pressor mechanism.
4. In the individual at rest, the venous return is primarily mediated through the tonic contraction of groups of muscle fibers.
5. As muscular tonus decreases, the venous return is commensurately decreased.
6. Tonus is mediated through a simple spinal reflex arc.
7. The activity of spinal neurons and therefor, of the spinal reflexes is subject to depression by a wide variety of stimuli.
8. As spinal reflex activity is depressed, muscular tonus falls and the amount of blood returned to the heart decreases.
9. If spinal reflex action is sufficiently depressed, there is a failure of the veno-pressor mechanism with inadequate venous return to the heart, commensurate decrease in cardiac out-put and cardiac stand-still.
10. An additional lethal factor is provided in certain cases by loss of tonus in respiratory muscles with contributing asphyxia.
11. Many cases of death attributed to failure of the vaso-motor center are, in actuality, failures in the veno-pressor mechanism.

Decrease in cardiac out-put leads to cardiac arrest through two main factors. One is that coronary circulation depends on diastolic filling. As cardiac out-put falls, the cardiac rate increases at the expense of diastole. This can only lead to cardiac ischemia. The second factor concerns the effect of anoxia on the spinal reflexes. They are depressed even further. leading to more and more pooling of blood in muscles, with less and less venous return to the heart, thereby compounding the felony.

Venous Return

The factors concerned in returning blood to the heart are the transmitted energy of the cardiac systole and the pressure gradient from the arterial to the venous side of the circulatory system, the negative intra-pleural pressure and the veno-pressor mechanism. The importance of the latter may be appreciated by considering that during muscular exercise the increased demand on the circulation is mainly provided by the accelerated return of venous blood by the obvious muscular contractions; in other words, the veno-pressor mechanism. During rest, the venous return can be studied by measuring the height of the column of blood in the veins of the arm, held vertically. Measurements taken by Henderson and Haggard indicate that

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the amount of return cannot be correlated to the blood-pressure; they can be correlated with muscular tonus. This was particularly brought out on their measurements taken on surgical cases, before and during anesthesia.

Spinal reflex activity can be simply measured by observing the knee-jerk. Electromyograms may be used to measure tonic activity. With these techniques it is possible to show marked decrease in spinal reflex activity, muscular tonus and cardiac venous return in acute and chronic illness. The same occurs in all conditions characterized by the term, "shock."

It is interesting that acapnia is followed by abolition of the knee-jerk, but rebreathing with a rise in blood carbon-dioxide induces a marked augmentation of the knee-jerk. The changes in blood-volume circulation produced by carbon-dioxide are usually attributed to cardiac effects through the chemo-receptors and vaso-motor center. Henderson suggests that it may be mediated through spinal reflex arcs and the alterations in the volume of venous return. In cases of shock, peripheral constriction of blood vessels is severe and obvious. Since this is mediated by the vaso-motor center, it is difficult to understand why the center is said to fail. It would appear, rather, that in almost every case where cardiac out-put falls, the vaso-motor center causes constriction of the arterial system to maintain arterial pressure.

Clinical Applications

The failure of the veno-pressor mechanism may not be the entire explanation in many cases of death but it does, at least, provide an explanation based on available data rather than on vague phrases. If it does not convince, it at least provides a stimulating hypothesis subject to further testing. It seems to have clinical as well as pathological applications.

Does the individual who faints at some unpleasant sight or upon receiving calamitous news, faint because higher centers are inhibited? Or is there profound vagal stimulation to the heart, with a temporary cardiac arrest and cerebral anoxia? Or does the individual faint because of an abrupt suppression in spinal reflex activity and its consequent train of events? Does the individual in shock have low cardiac out-put because of splanchnic pooling or because of muscular pooling? Does the lethal equivalent of fainting, death by inhibition, occur because of vagal cardiac arrest or failure of the veno-pressor mechanism? Does the chronically ill, weakened, emaciated patient die because he has "gone down-hill" or does he die because some trifling insult depresses his already depressed spinal reflex activity and muscular tonus to where there is complete failure of the veno-pressor mechanism? Are patients, after acute illness, weakened or debilitated, or do they suffer from a loss of muscle tonus?

It is interesting to note that prior to the discovery of tonus, physicians prescribed tonics. One wonders whether there is a place today for modern tonics — measures to promote healthy spinal reflex activity and normal muscle tonus.

It would seem, then, that if there is any validity at all to the role of the veno-pressor mechanism as a cause of death, the study of death becomes a fertile field with potential benefits to the living.

Reference

1. Henderson, Y. Tonus and Venopressor Mechanism; Medicine 22: 233, 1943.

The Children's Hospital

Acute Disseminated Histoplasmosis

Report of a Fatal Case with Hypofibrinogenemia and Gastrointestinal Hemorrhage*

G. J., a 5-month-old white female, was admitted to The Children's Hospital on February 19, 1959, with the chief complaints of fever and vomiting. For the past week the patient had been febrile and lethargic. For three days before admission she had vomited one or two times daily, had a few mucoid, greenish, loose stools; and on the day of admission, she had become more lethargic and refused all food and liquids.

The birth weight was 6 lbs. 10 ozs. The child was thought to be in good health prior to the present illness. The family lives in northern Kentucky and is in good health.

Physical Examination

At the time of admission, the child was fairly well developed and nourished, but appeared acutely ill, drowsy, irritable and moderately dehydrated. Temperature of 99° (F), rectally; pulse, 138 per minute; respirations, 60 per minute; blood pressure, 86 systolic (palpation), weight, 14 lbs.; height, 26½ ins. The skin was not remarkable except for pallor. The anterior fontanelle was slightly sunken. Three examiners considered the neck markedly stiff. The lungs were clear, but there was slight subcostal retraction. Hepatosplenomegaly was marked, the liver being 7 cm. below the right costal margin, and the spleen 6 cm. below the left costal margin. There was no lymphadenopathy.

Laboratory Findings

Initial laboratory findings were:

1. An immediate lumbar puncture was within normal limits except for a protein of 74 mgm.%.

2. Hemogram showed a hemoglobin of 8.6 gms.%; WBC, 3,600 with 56% polymorphonuclear forms.

3. Urinalysis within normal limits except for a small amount of acetone.

4. Chest x-ray normal.

Clinical Course

The infant was given intravenous fluids to correct the dehydration, then was given 150 ml. of whole blood. It was noticed that there was prolonged oozing of blood from the site of the femoral puncture for typing and cross-matching of blood. It was felt that the child had either leukemia or disseminated histoplasmosis, and a bone marrow examination was performed. There was no evidence of leukemia, but several granulomatous lesions were seen along with many organisms consistent with Histoplasma capsulatum.

This diagnosis was soon corroborated by growth of the organism from bone marrow culture. However, the clinical condition worsened, the child becoming extremely irritable with rapid, shallow respirations. She was placed in a croupette with oxygen. Abdominal distention occurred and a tarry stool was passed. Oozing of blood was prolonged from the site of the bone marrow aspiration. The tuberculin (5 Tuberculin Units of PPD) and histoplasmin (0.1 ml. of 1:100 dil.) skin tests were negative at 48 hours.

C. H. No. 74389

On the third hospital day treatment was started with amphotericin B.*

Amphotericin B dosage for Disseminated Histoplasmosis

1. Starting intravenous dose of 0.25 mgm. per kg. (Maximum dosage of 1.0 mgm. per kg.)
2. Calculated amount dissolved in 5% dextrose in water in concentration of 1.0 mgm. of drug per 10 ml. solution.
3. Infusion given in a 6-hour period.
4. Drug is given daily for 4 to 8 weeks.

Four hours after the infusion was begun, the temperature rose to 104° (F), the pulse to 200, and slight cyanosis occurred. The reactions were controlled with aqueous epinephrine and an antihistamine. The patient became more distended and blood was still oozing from the site of the bone marrow aspiration. Bleeding and coagulation times were markedly increased. The platelet count was 50,000 per cubic mm. A similar reaction occurred on the second day of the amphotericin B therapy despite epinephrine in oil and an antihistamine prior to the infusion. Emesis of dark brown material was noted.

On the third day of therapy, the patient was flaccid and continued to vomit dark brown material. The prothrombin time was markedly prolonged and fibrinogen was practically absent from the plasma. The hemoglobin was 10.0 gms.%. An attempt at drawing an NPN was deferred due to the large hematoma formation at the puncture site. The patient was given vitamin K and fibrinogen, intravenously.

The next morning blood was oozing from the nose and the infant was obtunded, pale and cyanotic. Gastric lavage yielded 2 ounces of black fluid. The hemoglobin had dropped to 6.4 gms. and 100 ml. of whole blood was given. The patient expired on the evening of the seventh hospital day. Permission for an autopsy was not obtainable.

Case Discussion

Doctor Joseph A. Little: When we see an infant at the Louisville Children's Hospital with fever, splenomegaly and anemia, we first think of leukemia or disseminated histoplasmosis. The bone marrow then becomes our main diagnostic tool. Leukemia can be diagnosed by the morphology of the marrow elements. In this case, the presence of granulomata and organisms similar to Histoplasma capsulatum were certainly sufficient grounds to institute therapy. Culture subsequently gave the definitive diagnosis.

Histoplasmosis is world-wide in extent, but is really endemic in the east-central states, such as Kentucky, Tennessee, Missouri, Arkansas, southern Illinois, Indiana and Ohio, where more than half the adults have a positive histoplasmin skin test. The mode of transmission is unknown, but is probably by inhalation or ingestion of spores. The disease is not spread from man to man, or from animal to man.

Pathologically, it is convenient to think of the disease as very similar to coccidiodomycosis or tuberculosis. Just as Californians think of coccidiodomycosis as San Joaquin Valley fever, our house staff calls histoplasmosis "Ohio Valley Fever." The yeast forms of Histoplasma capsulatum produce granulomatous lesions throughout the reticulo-endothelial system which are very similar to those of tuberculosis. Granulomatous reactions with giant cells and even caseous necrosis are seen. The chest x-rays can easily be confused.

The tuberculin and histoplasmin skin tests have roughly the same significance, and are frequently negative in an overwhelming infection. In over half the cases of disseminated histoplasmosis, the skin tests are negative.

This case, with fever, irritability, weight loss, hepatosplenomegaly, some diarrhea and pallor, is a fairly classical one of the disseminated form of the disease. Had purpura been present at the onset, the clinical differentiation from leukemia would have been even more difficult. Bleeding tendencies are a late, and usually bad prognostic sign, indicating marked encroachment upon the marrow, and probably the liver, by the reticulo-endothelial reaction to the fungus. Crowding out of the marrow was responsible for the anemia, leukopenia and thrombocytopenia. Massive infiltration of the liver caused the prolonged prothrombin time and depletion of fibrinogen in this patient. A post-mortem liver biopsy showed almost complete disintegration of the liver cell architecture and tremendous numbers of the Histoplasma capsulatum organisms.

Although the bone marrow studies are of

*Available as Fungizone® (Squibb).

prime importance in the diagnosis of the disseminated form of the disease, complement-fixation tests and the agar-gel tests of Heiner[1] are useful.

Until recently, disseminated histoplasmosis was usually fatal. Several collaborators and I[2] reported four cases successfully treated with amphotericin B. Since that report, I have treated two more children successfully plus this case. Amphotericin B is a powerful drug and should be used with great caution and on sound clinical grounds. Side effects such as headache, nausea, vomiting, chills, fever, cyanosis, and elevated NPN are often seen. Usually these reactions can be controlled so that the therapy can be continued. We are hopeful that by using this agent, acute disseminated histoplasmosis can be controlled in those cases diagnosed before irreparable damage has been done.

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1. Heiner, D. C., Diagnosis of Histoplasmosis, Pediatrics, 22:616, 1958.
2. Little, J., Bruce, J., Andrews, H., Crawford, K., and McKinley, G., Treatment of Disseminated Infantile Histoplasmosis with Amphotericin B., Pediatrics, 24:1, 1959.

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SPECIAL ARTICLES



How Changing Public Attitudes Affect Medicine*

GERALD J. SKIBBINS†

THE point of this address is simple: Whatever you want for the future of American medicine, you can have.

Although you now face socialized medicine for the aged, and a vicious attack on the pharmaceutical industry, plus trade-union agitation for a totally socialized medical practice, I repeat: Whatever you want for the future of American medicine, you can have.

The advances in communications theory, in attitude measurement, in social theory, and in the scope of our communications network have given you this option. There is today no hidden or unsolvable problem which prevents organized medicine from achieving its highest goals. None, whatsoever.

However, it is much more likely that British experience will be repeated here and that your life as a doctor will go something like the first chapter of Philip Auld's book, "Honour a Physician." Auld is the pseudonym for a British G. P. who wrote down his actual experiences under 10 years of the National Health Service.

The Way It Began In England

This was the beginning, in 1948:

"England 1948—Dr. Charles Gatwood started his middle-aged car and backed cautiously through the gate. Pausing to inspect the road, he became aware of Alderman Sydney Carb's untimely presence, hand upraised to signal a desire for converse. He cursed beneath his breath, looked pointedly at his watch and applied the handbrake.

" 'Ah, Doctor! I've been wanting to have a word with you . . .'

" 'Afraid I can't stop, Mr. Carb. . . '

" '*Alderman* Carb, *if* you don't mind! '

"Gatwood grinned. 'I don't mind a bit. '

"The alderman frowned, then allowed his face to clear and passed to the next business. 'What I was going to say was that we've got you in after all.' He neighed triumphantly.

"Gatwood looked puzzled. 'I don't understand. Got me in what?' He switched off the engine.

' 'The doctors, I mean. In the Health Service. I didn't think you'd resist for long.'

" 'Oh, I see,' said Gatwood thoughtfully. 'You've got us in. You have a happy way of putting it, Alderman. You make it sound as though we've been trapped.'

" 'I reckon you can say that again!' His snicker was shattered by an explosive cough into Gatwood's face. He recovered his breath and proceeded without apology: 'You doctors have had the public under your thumbs for long enough. Now the boot's going to be on the other foot . . . I was saying to Fred only yesterday—the Mayor, you know—I said to him, I said, Fred, I said, now we can put them clever fellows where they belong, I said. They're going to be paid by the people and they'll be answerable to the people, I said.'

" 'I thought we always were paid by the people. When we were paid, that is. Look here, I'm not sure what you're getting at, with your thumbs and your boots, but you make it all sound very unpleasant. Do you mean we're going to be sorry we entered the service. Is that what you're looking forward to?'

" 'Now I wouldn't say that, Doctor. No, I wouldn't like to go so far as to say that. No. But there'll be changes, y'know. Bound to be. No use blinking the fact.'

" 'What sort of changes?'

" 'Well, for one thing, the public are going to see to it that you chaps provide the sort of service they want and, what's more, *when and where they want it.*

---

*Presented at the 10th Annual County Society Officers Conference in Bowling Green, Kentucky, on March 31, 1960.

†Research Executive, Opinion Research Corporation, Princeton, N. J.

Instead of acting superior to the community as you've always done, now you're an equal part of it.' His eyes gleamed with jubilant anticipation.

"'You know, I'd always thought we served the community pretty well, on the whole. As for being an equal part of it, very few of the other parts seem to be particularly equal, so I don't know where you intend to fit us in. In any case, I shouldn't push the idea too hard, or we might take you at your word.'

"Carb looked blank. 'How d'you mean, Doctor?'

"'We might decide to work the same hours as the rest of our equals, for example.'

"The aldermanic brow furrowed horizontally with amazement. 'But your vocation, Doctor! What about your vocation?'

"Gatwood smiled. 'You're the one who wants the changes. If you insist that there's to be nothing to choose between doctors and the rest of the community, you must expect the same sense of vocation as you get from other workers, which is precious dam' little when you see them from my side of the desk. No use blinking the fact, as you say, Alderman.'

"The lower furrows became vertical with annoyance. 'Now then, Doctor, I'm not having you run down the working man. He's . . . '

"Gatwood interrupted him impatiently: 'Nobody's running down the working man. He's usually a good chap, and I like looking after him, but he varies a bit, like everyone else. If you spent a few Monday mornings in my surgery you'd know what I mean. The point is that he's fussy about the number of hours he works, and you apparently want doctors to be the same.'

"'The working man does a fair day's work for a fair day's pay. He's the wealth of the country, and . . .'

"Gatwood cut in again before the cliches got out of control. 'There's nothing you can tell me about the working man, Alderman. You don't see him with his pants down as I do. At least, I hope not.'"

Public Relations War Lost

Britain presents a case history of an association leadership and a profession that lost a public relations war: free medicine lost first in the attitudes of the British public, next in the society's accepted economic philosophy and finally among doctors themselves and in their own councils.

I leave you to draw your own conclusions on whether the attitudes and beliefs of your neighbors about medical care have anything to do with your future in medicine. I submit that the attitude research evidence that was produced in our recent study, "The Public Relations of Medicine," shows that here in America you need not, but certainly could be socialized.

Let's concentrate on the main theme that medical practice in America can remain free, if we so desire.

How can this be done?

Seven-Point Technique

The method is rational, practical and sure. A control concept for this effort would be:

1. Measure public attitudes among the people that you wish to influence. In other words, take a hard, cold look at yourselves as others see you.

2. Decide which changes in public attitudes are needed for a "cure."

3. Decide on the communicating or action program which will best effect each change needed.

4. Test it to see whether it works with people.

5. Apply it with ample resources and personal support.

6. Remeasure to find out whether you, in fact, effected any change.

7. Continue to: Decide on strategy, test, act, measure.

And that is the technique established in the literature and in attitude research. It works. And for the sake of the freedom of medicine in this country, I hope it gets applied by everyone in the profession, individually in each doctor's practice and in groups such as this. If it does not sound new or world-shaking to you, then explain why it is not being used on the scale necessary to prevent socialized medicine in America.

Unpleasant Facts to Face

In applying this concept, we'll have to face some unpleasant facts:

1. The opposition is smart.

2. Our recent survey for AMA showed that many people look to government more than to organized medicine for future leadership in advancing the nation's health because they feel that government will be more likely to reflect the best interests of *all* the people.

3. The general public also showed that rather poor communications and financial relations exist now between the doctor group and the people. This remains an unresolved source of trouble.

4. The cost of a full-scale communications

effort in dollars would drive society membership fees many times higher than at present. It would take a major commitment from all physicians.

5. Physicians will find no way to delegate all of this monumental task to society officers or staff. Each man's life will change as he accepts this commitment to his future. "Business as usual," whether professional or commercial, is not sufficient to the day if it means ignoring this attack on the very fundamentals of your profession.

Must Want to Win

You will really have to want to win, enough to change your practice to meet this challenge—to devote time each week to the argument and the cause.

In summary, in my opinion, your great profession really merits full public confidence but does not now have that insulation. This is an unfortunate fact. Adverse legislation is thus possible, perhaps probable.

To give you hope, however, let me cite the public utilities who, since 1948, waged a large-scale war of ideas to slow the federalization of electric power. They have done rather well, in my opinion, in carrying their sound viewpoint into public awareness and acceptance throughout most of the nation. There is much less criticism today of the industry.

On the other hand, the commodity markets of the Chicago Board of Trade and the New York Cotton Exchange are almost completely shut down by the federalization of agriculture. They went down almost silently. Agriculture itself is giving up its independence too. Yesterday 1,000 New Jersey egg farmers voted to ask Jimmy Hoffa to organize them into a pressure group. Their markets are evaporating and they want a way to force people to buy their products.

You, however, have been vocal and active although largely on the defensive. Perhaps now the medical profession might feel ready to take the offensive on a large scale.

There are many good leaders among you. Elevate them!

You have a powerful, well-regarded Association, the AMA. Give it more support and more of your time and guidance!

You have great resources and ideas. Use them!

American People Receptive

Our research shows the American people are receptive to your message. Give it to them with honesty, fairness and courtesy, being sure that it is repeated often enough to everyone to understand your story.

I hope I have made it clear that it will take a *tremendous* continuing effort to establish in the minds and hearts of your fellow Americans the insulation from attack your profession deserves.

In this modern world, that task will never end, but it can be controlled to operate at a successful level. After all, the public needs to have physicians who are successful, respected and able to provide the best of medical care.

The ideal is in the quotation from Ecclesiasticus found on the frontispiece of Philip Auld's book:

"Honour a physician with the honour due unto him for the uses which ye may have of him."

Have You Changed Your Address Recently?

If so, please notify

The KSMA Headquarters Office

1169 Eastern Parkway, Louisville 17, Ky.

EDITORIALS

Health Mobilization In Kentucky*

A NEW approach to emergency health and medical care services has been made with the creation of the Division of Health Mobilization within the framework of the U. S. Public Health Service. The Division was established by the Surgeon General, Dr. Leroy E. Burney, on May 1, 1959, to implement health responsibilities assigned to the Department of Health, Education and Welfare by the Executive Office of the President—Office of Civil and Defense Mobilization.

In addition to determining the health and medical needs of the nation during an emergency, the Division is responsible for establishing an operational capability to implement these plans. Basically, the objectives of the Division are: to prepare national emergency plans and develop preparedness programs in health services, civilian health manpower and resources; to prepare and institute training, research and health resource programs at the national and regional level; to provide consultation and advice to states and communities on implementing these plans if necessary, and to develop health rehabilitation and restoration plans to be used following an emergency.

The Division has established a prototype regional program in DHEW Region III, with headquarters in Charlottesville, Virginia, to carry out its responsibilities to the states and communities. Kentucky, Maryland, Virginia, West Virginia and the District of Columbia, which are common to both OCDM Region II and DHEW Region III, are the states to receive assistance in this test operation. The basic objective of the regional program is to assist the State Departments of Health in implementing and developing state-level health and medical services as delegated in their OCDM-approved State Operational Survival Plans. The regional program, then, is considered to be one of action—not further planning. Plans already developed must be activated and tested.

To accomplish this objective, the regional office has been staffed with qualified medical and other professional personnel; a full-time Health Mobilization Program consultant has been assigned to each State Department of Health and OCDM Region II, and 10 doctors or allied medical personnel have been recruited from each state in the region to provide community leadership on a part-time basis.

The regional program, when developed, will mean a built-in civil defense capability whereby normal peace-time relationships between the U. S. Public Health Service, State Department of Health and private medicine will be maintained as far as possible.

Based on the State Survival Plans, public health services are responsible for health protection services as well as the framework of organization for the continuity of government. Private medicine holds responsibilities for medical care, hospitals and blood services. Both groups will be represented at all levels of command and control, and must work in close relationship to meet a possible national emergency.

The 10 "cadre" selected from each state will be the backbone of the regional program. Their

**This paper prepared by: Russell E. Teague, M.D., Commissioner of Health, Commonwealth of Kentucky; George Moore, M.D., Chief, Health Mobilization, Department of Health, Education and Welfare, Region III, Charlottesville, Va., and Forrest D. Stokes, Public Health Advisor, U. S. Public Health Service, Frankfort, Ky.*

major objective will be to provide the incentive necessary to develop mutual aid plans between target cities and their support counties. This will be accomplished through cadre assistance to Area Health and Medical Advisory Committees in solving the problems of evacuation assignment, health manpower and resources needs, Civil Defense Emergency Hospital locations and other necessary health mobilization measures. The regional office staff at Charlottesville will provide continual assistance to carry out their functions.

The job to be done will take a great deal of time and effort. It will also require teamwork. But each little accomplishment means more lives saved in time of national emergency. Hopefully, the knowledge gained will never be tested in a thermonuclear attack, but this has its application to peace-time as well. It will not be wasted should war never come.

Cancer Prevention

UTERINE cancer is a comprehensive term, often used interchangeably with cancer of the uterus to describe either cancer of the cervix or corpus. Approximately 75 per cent of uterine cancer occurs in the cervix and the remainder in the corpus.

Uterine cancer is the second most common cancer in women (breast cancer being most common). Out of the 34.3 million women between the ages of 35-70, about 32,000 will get uterine cancer this year, of which 23,000 will be cancer of the cervix. The rate of new cases of uterine cancer is twice as high among Negro women as among white women. The greatest incidence of uterine cancer comes after the age of 32; however, no age group is immune. Cancer of the reproductive organs (including the ovaries, fallopian tubes, as well as the corpus and cervix of the uterus) causes 23,000 deaths among women each year, of which 15,000 are from uterine cancer.

About 55 per cent of uterine cancer patients are now being saved. A cell examination for uterine cancer, often called the "Pap Smear," might make possible a cervical cancer cure rate of nearly 100 per cent. This examination, an aid to earlier diagnosis, is based on the study of cells which are normally shed from living tissue (exfoliative cytology). If cancer is present or just beginning, the cells show characteristic changes from normal which can be recognized under a microscope. These cells are obtained by a smear from the cervix.

The physician may easily, and without pain to the patient, remove a sample of secretion that contains the castoff cells for microscopic examination. The sample is placed on a slide, stained and studied by a pathologist who may find cancer cells even when it is too early for the cancer to be detected otherwise.

A health checkup once a year, including a pelvic examination and the "Pap Smear" for uterine cancer, is recommended for all adult women.

Through education it is a known fact that lives may be saved from cancer. The American Cancer Society has an educational sound-technicolor film, narrated by Vincent Meigs, M.D., for lay groups that stresses the importance of the cytology examination. This film is available for your use; however, it may not be shown without the endorsement of the county medical society and a physician in attendance. We strongly urge that this educational film be shown.

The membership of the Kentucky Society of Pathologists will be happy to provide you with the materials for cytology specimens. Please write us for the name of the laboratory in your area that is doing work in cytology, or for information concerning the uterine cancer film.

The KSMA Advisory Committee on Public Health feels that by the use of some of the above points, we as physicians can play an important part in the early detection of cancer and we will be glad to cooperate with you in furnishing you the names of the pathologists nearest to you.

Delmas M. Clardy, M.D.
Chairman, KSMA Advisory Committee
on Public Health

ORGANIZATION SECTION

Transatlantic Link Arranged For KSMA Annual Meeting

A transatlantic clinical pathological conference, the first to be presented at a state medical association meeting, will be one of the top features of the 1960 KSMA Annual Meeting which will be held at the Columbia Auditorium in Louisville, September 20-22.

According to Irvin Abell, Jr., M.D., KSMA president and chairman of the Committee on Scientific Assembly and Arrangements, the transatlantic link will be an hour-long program starting at 2 p.m. Wednesday, September 21. The Bromley Division of the British Medical Association in England will be the English participants.

The KSMA panel will be moderated by Beverly T. Towery, M.D., professor and chairman of the Department of Medicine at the University of Louisville. A second member of the four-man panel will be John D. Allen, M.D., Louisville, president of the Kentucky Pathological Society. The remaining members of the KSMA panel will be selected from the list of KSMA guest speakers after it is learned from the British the general area in which their case falls.

The transatlantic link will be sponsored by the Smith, Kline & French Laboratories. Three different lines between the two meeting places will be in use during the program—one for each group of the participants and one for the technicians looking after the physical aspects of the program, Doctor Abell said.

Large photographs of the four British panelists will be hung immediately above the location of the four KSMA panelists. As a member of the Bromley society speaks, a red light will come on under his picture, indicating to the audience to whom it is listening. Full discussion of both cases, together with visual aids, can be heard by the audiences both in Britain and at the Columbia Auditorium.

Physicians' Services Not Subject To New State Sales Tax

Professional services of physicians will not be subject to the sales tax that takes effect in Kentucky on July 1, the State Department of Revenue has ruled. Medicines and drugs, however, are taxable, under regulations filed on May 6.

Regulation SU-18, which explains the physician's responsibility under the new law, was supplied to The Journal through the courtesy of the Department of Revenue. It provides:

"Physicians and surgeons are the consumers of the materials, supplies, or other items of tangible personal property which they use in performing their services. The tax accordingly applies to the sale of the tangible personal property to them. Drugs, medicines and other tangible personal property which are personally administered by a physician or surgeon or by an assistant under his direction during treatment of a patient are not the subject of a 'retail sale.' Likewise, drugs and medicines and other tangible personal property which can only be compounded by a physician or surgeon or by an assistant under his direction are not the subject of a retail sale whether or not they are personally administered by such physician or surgeon or by an assistant under his direction.

"Any physician or surgeon who, for a separate charge, supplies or dispenses drugs, medicine, or other tangible personal property in any manner other than the manner described above is a retailer of such tangible personal property and the tax applies at the time of the delivery of the tangible personal property to the consumer."

Dr. Reckless to Address KSMA On Future Of Medicine

"The Facts of Life In the Future of American Medicine" is the topic chosen by John B. Reckless, M.B., Ch. B., Durham, N. C., for his address at the KSMA President's Luncheon at the Brown Hotel, Louisville, on September 21. The luncheon is one of the highlights of the Association's Annual Meeting.



Dr. Reckless

Doctor Reckless is a native of Staffordshire, England. He received his undergraduate and medical education at the University of Birmingham, England, graduating with the degrees of Bachelor of Medicine and Bachelor of Surgery. He worked under the British National Health Service in the University Hospital for one year and later spent a period of time in general practice both in an individual and in a group type of practice.

Doctor Reckless served as Deputy Assistant Medical Director with a British Military Division in North West Germany before coming to the United States in the fall of 1958. Since that time he has been in the Residency Training Program of the Department of Psychiatry at the Duke University Medical Center.

11 Medical Students Accepted For Rural Scholarships

Eleven of this year's 17 applicants for first loans from the KSMA's Rural Kentucky Medical Scholarship Fund have been accepted, and four have been placed on a reserve list should additional funds become available, according to C. C. Howard, M.D., Glasgow, fund chairman. The applicants were interviewed at a meeting of the fund's board of trustees on May 5 at the Kentucky Hotel in Louisville.

The new group brings to 199 the number of medical students who have been approved for loans from the scholarship fund since its establishment in 1946, records of its executive secretary, Bobbie R. Grogan, show. Of the 188 who have accepted scholarships in former years, 54 have completed medical school and are now practicing in rural areas. Nine will go into practice—or military service—this year; 16 will enter the field in 1961, another 16 in 1962, and 32 in 1963.

Doctor Howard, who originated the scholarship idea, reported at the meeting that Governor Combs had aided the fund by "lending" it $10,000 from his emergency fund. The General Assembly also has appropriated $25,000 a year for the next two years.

All officers of the fund were re-elected. In addition to Doctor Howard, these include: G. L. Simpson, M.D., Greenville, vice-chairman; Russell E. Teague, M.D., Louisville, treasurer; George D. Caldwell, Louisville, fiscal agent, and J. P. Sanford, Louisville, secretary.

New directors named are Russell Hall, M.D., Wheelwright; Delmas Clardy, M.D., Hopkinsville, and Carson Crabtree, M.D., Buffalo.

The 1960 fund recipients include two sophomores at the University of Louisville School of Medicine—Joe A. Nichols, Harrison county, and Frank Varney, Pike county. The other nine will enter medical schools as freshmen next fall. Attending the U. of L. will be Janet Sue Allen, Fulton county; Lloyd M. Browning, Perry county; Robert Long, Fayette county; Robert A. Padgett, Hardin county; Milton S. Stanley, Graves county, and Charles G. Tooley, Jefferson county. The remaining three will be in the inaugural class at the University of Kentucky College of Medicine, Lexington. They are: Joseph R. Bowling, II, Nelson county; James A. Cunningham, Trigg county, and Helmuth Scherer, Scott county.



James A. Cunningham, seated right, of Cadiz, was one of 11 medical students granted first loans by the Rural Kentucky Medical Scholarship Fund at a luncheon meeting of its board of trustees in Louisville on May 5. Here he is interviewed by, from left, J. Murray Kinsman, M.D., dean of the University of Louisville School of Medicine; Dr. Robert Straus, chairman of the admissions committee, University of Kentucky College of Medicine, Lexington, and G. L. Simpson, M.D., Greenville, fund vice-chairman.



Applicants for medical scholarships sat at three tables with members of the board. At the speakers table at top were, left to right, Mrs. John T. O'Neill and Doctor O'Neill, Leitchfield; Mrs. Si A. Past and Doctor Past, Olive Hill; C. C. Howard, M.D., Glasgow, chairman of the Rural Kentucky Medical Scholarship Fund; Mrs. Wendell Hurt, Doctor Hurt, Tompkinsville.



John W. Scott, M.D., center, Lexington, who was honored by the Fayette County Medical Society upon his retirement after 62 years of practice, posed with the guest speaker at the annual dinner meeting, May 10, Naip Tuna, M.D., left, associate professor of medicine at the University of Minnesota, and Matthew C. Darnell, M.D., Lexington, president of the Fayette Society.

Fayette Society Honors Dr. Scott For 62 Years of Service

John W. Scott, M.D., Lexington, was given a special honor at the annual dinner meeting of the Fayette County Medical Society, May 10, which was attended by approximately 250 members and guest physicians from central Kentucky, at the Lexington Country Club.

The recognition was given Doctor Scott, following his retirement after 62 years of practice in Fayette county. Society President Matthew C. Darnell, M.D., Lexington, called on Carl H. Fortune, M.D., chairman of a special committee, to read the citation.

The scientific feature of the program was presented by guest speaker Naip Tuna, M.D., associate professor of medicine, University of Minnesota. The presentation of Doctor Tuna, who took a residency at St. Joseph's Hospital in Lexington, was well received.

Doctor Scott was graduated from Centre College in 1893 and from the College of Physicians and Surgeons in 1896. He interned for two years in Bellevue Hospital in New York. Doctor Scott was the winner of the 1952 KSMA Distinguished Service Medal.

The citation read by Doctor Fortune follows:

"There are very few people who have had an influence on the present practice of medicine in Kentucky comparable to that of Doctor John Scott.

"Doctor Scott, you have held many official positions: President of the Fayette County Medical Society, President of the Kentucky State Medical Association, for many years delegate of the KSMA, Chief of the Medical Service at Good Samaritan and St. Joseph Hospital, to mention some of your official capacities. You are a member of various societies of your specialty. By your personal efforts you have added luster to medical practice in Kentucky.

"Those of us who have had the privilege of knowing you and working with you cherish a more personal feeling. We remember with gratitude how you have given of yourself in teaching the younger men in the profession. We honor the intellectual and moral integrity which commanded the respect of all of us. We admire the clean competition you have fostered in medical knowledge and skill, which redounded always to the benefit of the sick without injury to the honest physician striving to practice good medicine. We respect the fearless manner in which you have expressed your views and admire the tolerance which you have had for the views of others.

"We, of the Fayette County Medical Society, consider that you will do us an honor by accepting membership emeritus. We hope we may continue to have the benefit of your counsel in our meetings and the stimulus of your discussion of scientific papers."

Serving on the committee with Doctor Fortune were N. L. Bosworth, M.D., and W. D. Reddish, M.D.

Eight Scientific Consultants Named For KSMA Journal

Appointment of eight new members to the Board of Consultants on Scientific Articles of The Journal of KSMA has been announced by the editor, Sam A. Overstreet, M.D., Louisville, and his Advisory Committee.

The board is made up of 24 physicians, eight of whom are replaced each year. The members serve for three years and are ineligible to succeed themselves. Their responsibility is to review scientific articles submitted for publication in The Journal.

The eight new appointees, whose terms start July 1, represent six specialty groups. They are: Frank M. Gaines, Jr., M.D, Louisville, psychiatry; Crocker B. Clegg, M.D., Elizabethtown, surgery; John D. Allen, Jr., M.D., Louisville, pathology; James Blackerby, M.D., Stanford, general practice; William E. McDaniel, M.D., Lexington, dermatology; Ernest C. Strode, M.D., Lexington, surgery; Reginald J. Phillips, M.D., Owensboro, surgery, and Harold J. Schupbach, M.D., Owensboro, internal medicine.

The retiring members of the board are: John P. Bell, M.D., Louisville, psychiatry; John Dickinson, M.D., Glasgow, surgery; James B. Douglas, M.D., Louisville, radiology; Frank L. Duncan, M.D., Monticello, general practice; Ullin W. Leavell, M.D., Lexington, dermatology; Francis M. Massie, M.D., Lexington, surgery; C. Pittman Orr, M.D., Paducah, internal medicine, and Merrill W. Schell, M.D., Owensboro, surgery.

Doctor Overstreet expressed his appreciation to the consultants for their valuable behind-the-scenes services to The Journal and their cooperation with the editors in their constant efforts to improve the Scientific Section.

ACS, Anesthesiologists to Meet In French Lick, June 17-18

Arrangements are complete for the two-day meeting of the Kentucky and Indiana Chapters of the American College of Surgeons and the Kentucky and Indiana Anesthesiology Society, to be held Friday and Saturday, June 17-18, at the Sheraton Hotel, French Lick, Ind. Twenty-five scientific papers are scheduled for presentation, according to the program announced by William T. Rumage, Jr., M.D., Louisville, secretary-treasurer of the Kentucky Chapter, ACS.

Dr. Bell I. Wiley, professor of history at Emory University, Atlanta, will deliver the banquet address Saturday night, speaking on "Dear Folks." Doctor Bell, who has degrees from Asbury College, the University of Kentucky and Yale University, is the author of a number of books, including "Johnny Reb" and "Billy Yank."

The presidential address will be delivered Friday morning by Harold M. Trusler, M.D., F.A.C.S., Indianapolis, president of the Indiana Chapter, ACS. Ernest C. Strode, M.D., Lexington, president of the Kentucky Chapter, will preside at the Friday sessions.

The complete program follows:

Friday Morning

Moderator—Sam Seel, M.D., Memorial Center for Cancer and Allied Diseases, New York

SURGERY OF CANCER

Circulating Cancer Cells—James C. Drye, M.D., Louisville

Experiences In Regional Perfusion, University of Louisville Medical Center—Walter I. Hume, Jr., M.D., Louisville

The Care of the Terminal Cancer Patient—Willis D. Gatch, M.D., Indianapolis

TRAUMATIC SURGERY

Moderator—R. Arnold Griswold, M.D., Louisville

Burn Scar Deformities—Thomas Bauer, M.D., Indianapolis

The Management of Fractures of the Medical Malleolus—Charles F. Wood, M.D., Louisville

Traumatic Injuries and Lacerations of the Trachea and Major Bronchi—Stanley Battersby, M.D., Indianapolis.

The Control of Surgery—Harold M. Trusler, M.D., Indianapolis

Friday Afternoon

GYNECOLOGIC SURGERY

Moderator—Joe Vincent Meigs, M.D., Boston, Mass.

Pelvic Endometriosis—Francis Massie, M.D., Lexington ton

The Cause and Control of Hemorrhage in the Immediate Postoperative Period in Gynecologic Patients—David Bickel, M.D., South Bend, Ind.

Sin, Sex and Segregation—Harold H. Davidson, M.D., Evansville, Ind.

RECTAL AND COLONIC SURGERY

Moderator—R. J. Noer, M.D., Louisville

The Management of Malignancies of the Rectum and Rectosigmoid Colon in Elderly Patients — Mell B. Welborn, M.D., Evansville, Ind.

The Technique of Hemorrhoidectomy—James M. McIntyre, M.D., Indianapolis

Diverticulitis and Carcinoma of the Sigmoid Colon—Frank Cook, M.D., Resident in Surgery, University of Louisville.

Friday Night

Moderator—Joseph E. Hamilton, M.D., Louisville

ABDOMINAL SURGERY

The Combination of Spinal and Endotracheal Inhalation Anesthesia for Upper Abdominal Surgery—John H. Combs, M.D., Evansville, Ind.

The Problem of Mesenteric Vascular Thrombosis—R. E. Lempke, M.D., Indianapolis

Vagotomy for Bleeding Duodenal Ulcer — Howard E. Dorton, M.D., Lexington

THROMBOEMBOLIC DISEASE

Paravertebral Sympathetic Block — Richard H. Stein, M.D., Vincennes, Ind.

Predisposing Factors to Thromboembolic Disease—Thomas C. Moore, M.D., Muncie, Ind.

The Management of Pulmonary Embolism—Porter Mayo, M.D., Lexington

Thrombectomy in Acute Thrombophlebitis—J. A. Haller, M.D., Louisville

Saturday Morning

An Evaluation of Spinal Anesthesia and Post Partum Headache—Robert Lykins, M.D., Louisville

An Evaluation of Prinadol, a New Narcotic Agent—William Nash, M.D., Louisville

Cardiac Arrest—Fact or Fallacy—Saul Rubin, M.D., Lexington

Fluothane, Its Present Status—John Abajiah, Jr., M.D., professor of surgical anesthesia, University of Vermont

Saturday Afternoon

The Effect of Position, Premedication and Anesthesia on the Hypovolemic and Normovolemic Patient—Perry P. Volpitto, professor of anesthesiology, Medical College of Georgia, Augusta

Panel Discussion: **The Legal Aspects of Surgery and Anesthesia Problems**—Jack E. Pilcher, M.D., Indianapolis; Harry W. Ginty, Medical Protective Company, Fort Wayne, Ind., and J. Donald Dinning, Louisville.

Saturday Night

Toastmaster—Coleman C. Johnston, M.D., Lexington

The University of Louisville Medical Center—R. J. Noer, M.D., Louisville

Dear Folks—Dr. Bell I. Wiley, Atlanta

KAGP Installs Dr. Archer; Elects Dr. Morgan

John G. Archer, M.D., Prestonsburg, was installed as president of the Kentucky Academy of General Practice, as Edward B. Morgan, M.D., Louisville, was chosen president-elect of the KAGP at its annual meeting in Louisville, May 10-13.

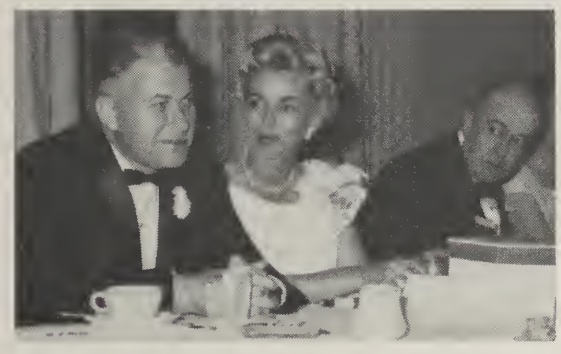


Dr. Morgan

Doctor Archer succeeded Daryl P. Harvey, M.D., Glasgow, as president, at the meeting attended by 238 members and guests physicians. A total of 807 registered at the meeting.

Governor Bert C. Combs was a guest of the Academy at the annual dinner. Doctor Archer, on behalf of the Governor, presented commissions as Kentucky Colonels to Doctor Harvey; J. Sankey Williams, M.D., Nicholasville, who was re-elected executive secretary of KAGP, and Homer Martin, M.D., Louisville, editor of the Journal of KAGP.

For the first time in the organization's history, the new Congress of Delegates functioned. Garnett J. Sweeney, M.D., Liberty, former KAGP president and former chairman of the KSMA Council and now vice speaker of the House of Delegates of KSMA, was elected the first speaker of the Congress.



Governor Bert T. Combs was the honored guest at the annual banquet of the Kentucky Academy of General Practice. On the Governor's left at the speakers table were old home-town friends from Prestonsburg, Mrs. John "Sandy" Archer and Doctor Archer, current KAGP president.

The state has now been divided into four regions, and vice-presidents elected for the various regions are: Thornton E. Bryan, M.D., Cadiz; George S. Allen, M.D., Louisville; Roy Wilson, M.D., Campbellsville, and Phillip J. Begley, M.D., Harlan.

The late Elgin S. Dunham, M.D., Edmonton, was the first post-humous winner of the Doctor of the Year Award, presented annually by the Kentucky Academy. Doctor Dunham, who died recently, had practiced in Edmonton for 20 years.

John F. Ganem, M.D., Louisville, for the second time in five years was given the Academy's award for outstanding research efforts during the past year.



The Clark Bailey cane, the new symbol of the office of president of KAGP, was presented by the retiring president, Daryl P. Harvey, M.D., center, Glasgow, to the incoming president, John G. Archer, M.D., Prestonsburg, at the organization's annual banquet. James W. Davis, M.D., seated, Louisville, was chairman of the program committee. The late Doctor Bailey, of Harlan, a founding and charter member of KAGP, was a past KSMA president.

New directors elected were: Harry Whayne, M.D., Murray; Sam D. Taylor, M.D., Henderson; Sydney Wayne Franz, M.D., Ashland; Thomas E. Averitt, M.D., Winchester; Preston Higgins, M.D., Hopkinsville, and Carroll Witten, M.D., Louisville.

6th District, Glasgow TB Hospital Plan Symposium July 18

The Sixth Councilor District of the KSMA and the State Tuberculosis Hospital, District Six, Glasgow, are jointly sponsoring a symposium scheduled for Monday, July 18, at the hospital. The program will begin at 6 p.m.

Announcement of the meeting was made by J. P. Glenn, M.D., Russellville, councilor of the district, and Malcolm H. Black, administrator of the hospital.

Richard F. Grise, M.D., Bowling Green, will represent the KSMA as essayist of a paper titled "Lesions of the Colon." The hospital's part of the program will be a "Review of Chest Surgical Consultation," with a review of cases by Nathan Levene, M.D., thoracic surgeon, and Julia Coelho, M.D., of the State Tuberculosis Hospital, District Two, Louisville, and E. F. Puess, M.D., medical director of the Glasgow hospital.

New KSMA Members Listed

New additions to the KSMA membership roster are:

Norman Fisher, M.D., Midway
J. Alex Haller, Jr., M.D., Louisville
Henry C. Jackson, M.D., Louisville
S. R. Scheen, Jr., M.D., Louisville

Two Biographies By Dr. Horine To Be Published This Year

The KSMA's official historian, Emmet Field Horine, M.D., of Brooks, is the author of two books scheduled for publication in 1960. Both are biographies of contemporary Kentucky physicians of the last century.



Dr. Horine

Daniel Drake (1785-1852) Pioneer Physician of the Midwest has been accepted by the University of Pennsylvania Press for release possibly in the late fall. *Biographical Sketch and Guide to the Writings of Charles Caldwell, M.D. (1772-1853),* published by High Acres Press of Brooks, will make its appearance early this month.

Doctor Horine describes his book about Daniel Drake as the first documented biography of the first honorary member of the Kentucky State Medical Association. Collection of material for it began in 1927.

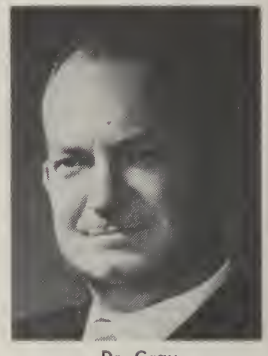
"At the time of his death in 1852, Drake was the most widely known and respected physician in the United States," his biographer says. "He had many firsts to his credit: he was the earliest known student of medicine to receive a certificate of proficiency; the first to write a book with a medical section published west of the Allegheny Mountains; a member of the first active faculty of Transylvania University; a leader in forming the first museum of antiquities and art in the West; organizer of three medical colleges, one of which, the Ohio Medical College, is still in existence as the University of Cincinnati College of Medicine.

"He was also the author of the most important book on medical education in the United States, which directly initiated the movement for higher standards in our profession . . . he edited the most influential western medical journal . . . his most notable achievement was the composition of 'one of the greatest masterpieces of medico-geographic research' described as his medical classic in our Journal (Vol. L, February 1952)."

About his other subject, Doctor Horine says: "Doctor Caldwell was one of the prime movers in reactivating the Medical Department of Transylvania University in 1819. In 1857, he sparked the opening of the Louisville Medical Institute, now the University of Louisville. In 1920, I began collecting books, essays and manuscripts by and about him. His interest in phrenology and hypnotism prompted the inclusion of a few early books in these disciplines. These (approximately 300) are to be given to the University of Louisville School of Medicine Library when the book is published."

Dr. Gray Is Author Of Textbook Of Gynecology—His Second

"A Textbook of Gynecology" is the title of a new medical book by Layman A. Gray, M.D., associate professor of obstetrics and gynecology at the University of Louisville School of Medicine. Released February 28, it already has been officially adopted by the U. of L. School of Medicine and Hahnemann Medical School of Philadelphia as their textbook of gynecology beginning in the fall of 1960.



Dr. Gray

Doctor Gray spent five and a half years collecting material, writing and revising the book—the second he has authored. The first, entitled "Vaginal Hysterectomy," published in 1955, has become a standard of teaching the operation in a number of hospitals and medical schools. Both books were published by Charles C. Thomas, Publisher, Springfield, Ill.

A 1932 graduate of Johns Hopkins Medical School, Doctor Gray finished five years of specialty training in gynecology before coming to Louisville in 1937 to work part-time as pathologist at Norton Infirmary and teach part-time at the Medical School. In 1938, he opened a private office in the Heyburn Building. From 1942-45, he was chief of the Women's Surgical Section, Walter Reed General Hospital.

At a meeting of the American College of Obstetricians and Gynecologists in Cincinnati in April, Doctor Gray was made chairman of the district which includes Michigan, Indiana, Ohio, Kentucky and Ontario. He will also represent these states on the executive board.

4 Kentuckians Named AAP Fellows

Four Kentucky physicians were among the 300 Fellows elected by the American Academy of Pediatrics at the organization's annual meeting in Atlantic City.

Receiving the honor were: Billy M. Adams, M.D.; J. W. Fowler, M.D., and Robert R. Kidd, M.D., all of Louisville, and Noble T. Macfarlane, Jr., M.D., Lexington.

Dr. Murray Elected to U.K. Board

Hershell B. Murray, M.D., West Liberty, is a new member of the University of Kentucky board of trustees. He was appointed by Governor Combs for a four-term term starting April 8.



A Kentucky Surgical Society trio talked with the guest speaker at the group's annual meeting in French Lick, Ind., on May 14. From left, are: C. Melvin Bernhard, M.D., Louisville, secretary; J. Duffy Hancock, M.D., Louisville, the new president; Bentley P. Colcock, M.D., Boston, Mass., guest speaker; Branham B. Baughman, M.D., Frankfort, retiring president.

Kentucky Surgical Society Elects Dr. Hancock

The Kentucky Surgical Society elected J. Duffy Hancock, M.D., Louisville, former KSMA president, as its 1960-61 president during its annual meeting Saturday, May 14, at French Lick, Ind.

Doctor Hancock succeeds Branham B. Baughman, M.D., Frankfort. John W. Dickinson, M.D., Glasgow, is the new vice-president, and C. Melvin Bernhardt, M.D., Louisville, began his second year as secretary-treasurer of the society, having been elected to a three-year term last year.

The 1961 meeting of the society will be held the second Saturday in May at French Lick. One hundred twenty-five members attended the meeting this year.

Six new members were inducted into the society which limits its active membership to 125. They were: George W. Cheek, M.D., Louisville; Royce E. Dawson, M.D., Owensboro; Reginald J. Phillips, M.D., Owensboro; John J. Robbins, M.D., Louisville; W. Fielding Rubel, M.D., Louisville, and Edward Warrick, Jr., M.D., Louisville.

At the dinner session, guest speaker Bentley Prescott Colcock, M.D., of the Lahey Clinic, Boston, Mass., was presented a Kentucky Colonel commission by retiring president, Doctor Baughman, on behalf of Governor Combs.

66 Attend Joint Meeting On May 5 Of 12th, 15th Districts

The joint meeting of the Twelfth and Fifteenth Councilor Districts at Cumberland Falls on May 5 drew an attendance of 66, including wives of members and other guests, it is reported by Thomas O. Meredith, M.D., Harrodsburg, and Keith P. Smith, M.D., Corbin, respective councilors of the two districts.

Irvin Abell, Jr., M.D., Louisville, president of KSMA, was the featured speaker on the program which was given at Dupont Lodge.

Four professors at the University of Louisville School of Medicine and a Lexington surgeon presented the scientific session. Essayists and their subjects were: Harry S. Andrews, M.D., associate professor of pediatrics, "Hypersensitivity In Children"; L. Douglas Atherton, M.D., instructor in urology, "The Enigmatic Female Bladder and Urethra"; Harold W. Baker, M.D., assistant professor of obstetrics and gynecology, "Adnexal Diseases—Diagnosis and Management"; Richard H. Segnitz, M.D., Lexington, "Gastro-Intestinal Tract Perforation In Infancy—Diagnostic and Management Woes," and John S. Llewellyn, M.D., instructor in medicine, "Early Diagnosis of Diabetes Mellitus."

Pediatricians Meet In Somerset

The Kentucky Pediatric Society, at its 11th annual meeting in Somerset April 6 and 7, elected Murvel C. Blair, M.D., Frankfort, as vice-president and E. P. Scott, M.D., Louisville, as secretary-treasurer.

Guest lecturers at the meeting were Sidney S. Gellis, M.D., Boston, Mass., and Loren G. MacKinney, M.D., Chapel Hill, N. C. A feature of the program was a panel of Kentucky pediatric surgeons, with Hugh B. Lynn, M.D., Louisville, as moderator, and Richard Segnitz, M.D., Lexington; Bernard J. Schoo, M.D., Louisville, and William W. Johnson, M.D., Louisville, as participants.



Pictured here as they returned from a field trip are the Kentuckians who took the training course in health and medical aspects of civil defense in Brooklyn, N. Y., April 18-23. The group includes, front row, left to right: Harold E. Shufflebarger, M.D., Grayson; John M. Baird, M.D., Danville; Carroll L. Witten, M.D., Louisville; William Burton Haley, M.D., Paducah; Edwin H. West, M.D., State Board of Health, Frankfort, and Forrest D. Stokes, U. S. Public Health Service, Frankfort; back row: Paul H. Klingenberg, M.D., Covington; William C. Gardner, M.D., Madisonville; George Moore, M.D., U. S. Public Health Service, Region III, Charlottesville, Va.; Charles F. Martin, M.D., Winchester; William B. Triplett, M.D., Owensboro; David L. Greeley, M.D., Harlan, and Alvin B. Coxwell, D.M.D., Louisville.

State Leads In Training Medical Officers For Civil Defense

Kentucky is the first state to select and train its full quota of medical officers under plans for health mobilization for civil defense, according to Forrest D. Stokes, Director of Health Mobilization, State Department of Health.

Nine physicians and one dentist made up a Kentucky team which accompanied Mr. Stokes to Brooklyn, N. Y., to take a special five-day course in medical aspects of health mobilization at the Office of Civil and Defense Mobilization Training Center, April 18-23. Members of the American Medical Association's Committee on Disaster Medical Care were among those in attendance.

The 10 Kentuckians are among 50 physicians who will be Public Health Service Inactive Reserve Officers assigned health mobilization responsibilities within the District of Columbia, Kentucky, Virginia, West Virginia and Maryland. As health service cadre officers, they will coordinate medical services for a local area in a national, statewide or local disaster.

They will be responsible to Russell E. Teague, M.D., State Commissioner of Health, appointed by the Governor to direct emergency medical services for Kentucky civil defense. Doctor Teague's alternate is Edwin H. West, M.D., Louisville, who also took the training course in Brooklyn.

The nine physicians on the Kentucky team are: John M. Baird, M.D., Danville; William C. Gardner, M.D., Madisonville; David L. Greeley, M.D., Harlan; William Burton Haley, M.D., Paducah; Paul H. Klingenberg, M.D., Covington; Charles F. Martin, M.D., Winchester; Harold E. Shufflebarger, M.D., Grayson; William B. Triplett, M.D., Owensboro, and Carroll L. Witten, M.D., Louisville. The 10th member is Alvin Bartley Coxwell, D.M.D., Louisville.

Dr. Bell, Noted Radiologist, Dies In Louisville

Joseph C. Bell, M.D., Louisville, nationally-known radiologist, died on April 25 at Norton Memorial Infirmary, Louisville, at the age of 67. He was the senior partner in the firm of Doctors Bell, Douglas, Peterson, Blackburn & Hale, radiologists.



Dr. Bell

Doctor Bell was the first case discussion editor of the KSMA Journal and was active in improvement of the Journal generally. He was a charter member of the board of directors of Kentucky Physicians Mutual, Kentucky's Blue Shield Plan.

A native of Pennsylvania, Doctor Bell attended Harvard Medical School. He was attached to the Presbyterian Hospital in New York before moving to Louisville. He served overseas in World War I, was a lieutenant commander in the Naval Reserve in the mid-1930's, and returned to active duty in the Army in World War II as chief of the X-ray section of Percy Jones General Hospital, Battle Creek, Mich., with the rank of lieutenant-colonel in the Medical Corps.

Doctor Bell was professor of radiology at the University of Louisville School of Medicine and was a founder and former president of the Kentucky Radiological Society. He was a diplomate of the American Board of Radiology and a member of the Harvey Cushing Society. In 1952, he was president of the Radiological Society of North America.

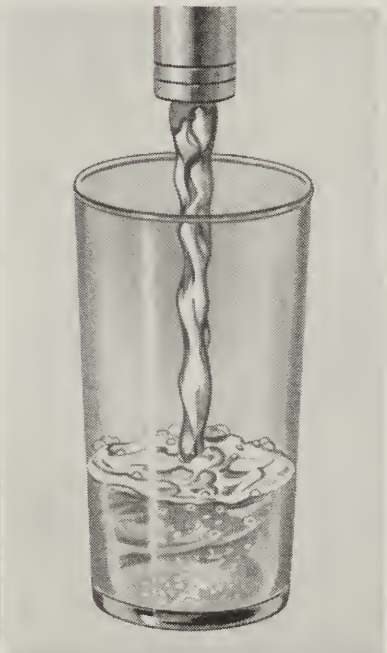
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KSMA Active In Drive to Revise State Constitution

The county medical society secretaries have been notified by KSMA President Irvin Abell, Jr., M.D., Louisville, that their names make up a list submitted to Governor Combs for his consideration in appointing a Citizens Council to help speed the drive for a limited convention to revise the 1890-91 State Constitution. Kentuckians will vote on the call for such a convention at the general election on November 8.

The KSMA, at its 1959 Annual Meeting, adopted a resolution calling for a convention to revise the Constitution. In addition, the delegates urged further study and support of all interested groups. The resolution was proposed by the Jefferson County Medical Society.

Spearheading the drive is the Constitutional Revision Commission, which held its organizational meeting in Frankfort on May 19 and elected as its chairman, Parker W. Duncan, Bowling Green, former judge of the Court of Appeals. The commission was appointed by Governor Combs as provided by House Bill 168 of the 1960 Session of the General Assembly.

Federal Employees Eligible July 1 For Health Benefits

The Federal Employees Health Benefits Act of 1959 has now become Public Law 86-382, which means that government employees will be eligible for group hospital-surgical benefits with the government as the employer paying part of the cost.

The exact amount which the government will pay will be determined by the over-all cost of the program which is chosen. If the total charge for the plan is less than $5.60 (single) or $13.50 (family) a month—then the government will contribute one-half the cost.

Except in this situation, the government will contribute not less than these specified amounts:

$2.80 a month for employee only;
$6.75 a month for employee and family.

No employee is required to sign up for any of the plans, but those who elect to do so (for the purpose of Federal employees in Kentucky) would have a choice of (a) a service plan or (b) an indemnity plan. (This is assuming that they do not choose an employee-organization benefit plan).

Each plan will have two "level of benefits" choices. Both Blue Cross-Blue Shield and the insurance industry will offer catastrophic protection over the regular benefits against the more unusual and heavy expense of serious or prolonged illness.

This law becomes effective on July 1, 1960. Health benefits will not begin until the first pay period after June 30, 1960.

For additional information, write the Kentucky Blue Cross-Blue Shield Plan, 3101 Bardstown Road, Louisville, Ky.

Physician's Larger Role Pictured By Senior Day Speaker

"People expect more of businessmen, doctors, lawyers, or what have you, and the skills which served an earlier day are not adequate for today," Lester H. Means, manager-government relations for General Electric's Major Appliance Park, pointed out in addressing the dinner meeting of the Sixth Annual Senior Day, May 6, sponsored by the Kentucky State Medical Association. His topic was "Why Live So Long."

The speaker was introduced by N. L. Bosworth, M.D., Lexington, chairman of the KSMA Senior Day Committee, who expressed deep appreciation to the University of Louisville School of Medicine and the Jefferson County Medical Society, which cooperate in the annual event honoring the senior medical students at the U. of L.

"The doctors, and the businessmen, are sometimes pictured as reactionary defenders of the status quo," Mr. Means said, "but it might be more accurate to say that in the United States there is no status quo. There is only a changing pattern of innovation and obsolescence. Let us have the humility and the frankness to admit that our attitudes and skills, like those of others, are subject to rapid obsolescence in this age of change."

Recalling that there was a time when business operations, and doctors' offices, were run almost on a day-to-day basis, the speaker said that today the manager and the doctor must anticipate the future and plan ahead—preferably 10 to 20 years ahead—if they are to remain competitive in serving customers or patients successfully.

"The whole political and social environment in which business operates has changed, is changing, and will continue to change," Mr. Means declared. "Increasingly the people expect all of us not only to satisfy their material wants and desires, but also to satisfy a whole range of psychological and ethical expectations. Most of these expectations are basically reasonable, and it is the responsibility of all of us to recognize them."

Irvin Abell, Jr., M.D., Louisville, president of the KSMA, addressed the medical seniors at the morning session which was held in the Rankin Amphitheater, Louisville General Hospital. He spoke on "The Last Chance."

KSMA members who participated in the afternoon program presented at the Brown Hotel, Louisville, included: Doctor Bosworth; Oscar Hayes, M.D., Louisville; Carl Fortune, M.D., Lexington; Sam A. Overstreet, M.D., Louisville; Garnett J. Sweeney, M.D., Liberty; Carl Cooper, M.D., Bedford; Wyatt Norvell, M.D., New Castle; Frank Moore, M.D., Bowling Green; Donald Dudderar, M.D., Newport; David M. Cox, M.D., Louisville, and Douglas Scott, M.D., Lexington.

George W. Pedigo, M.D., Louisville, president of the Jefferson County Medical Society, presided at the dinner meeting.

(Participants in day's activities are pictured on opposite page)







Tips on the practical side of medicine were presented by practicing physicians of the state to seniors at the University of Louisville School of Medicine during 1960 Senior Day activities in Louisville on May 16.

Top—The day opened with a program at General Hospital, featuring an address by the KSMA President, Irvin Abell, Jr., second from left, Louisville. Other participants were, left to right, N. L. Bosworth, M. D., Lexington, chairman of the KSMA Senior Day Committee; J. Murray Kinsman, M. D., dean of the U. of L. School of Medicine, and Robert McKechnie, president of the U. of L. Chapter, Student AMA.

Center—At a tea given at the Brown Hotel for wives and sweethearts of the medical seniors, Mrs. C. B. Johnson, left, Russell, president of the Woman's Auxiliary to KSMA, served Robert Long, M. D., Louisville, the speaker; Mrs. Robert A. Smith, Louisville, retiring president of the AKK Wives Club, and Mrs. Walter Scott, Louisville.

Bottom—At the banquet given by the Jefferson County Medical Society, Hoyt D. Gardner, M. D., left, Louisville, the society's Senior Day chairman, talked with James E. Gamble, president of the U. of L. Senior Class; Doctor Bosworth; Lester H. Means, banquet speaker, and George W. Pedigo, Jr., M. D., Louisville, president of the Jefferson County Society.

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Digest Of Minutes Of the Meeting of the KSMA Council, March 30, 1960*

THE Council held its third meeting of the 1959-60 associational year at Owensboro, prior to the County Society Officers Conference. After hearing the president's report and the Headquarters Office Report, the proposed budget for the 1960-61 associational year was presented. It was explained that the Budget Committee had spent a day going over and approving the budget as proposed, and that the Executive Committee had given careful attention to it, approved it, and recommended to the Council that it be accepted.

After discussion, the Council voted unanimously to accept the budget and approved a recommendation of the Budget Committee passed along through the Executive Committee that the Association appoint an investment committee, composed of the president of the Association, the chairman of the Council, and Keith Smith, M.D., Councilor from the Fifteenth District, to serve as an investment committee.

New Sales Tax Discussed

The Council then heard a discussion of how the new sales tax might apply to physicians, and it was stated unofficially that medicines given by physicians in the treatment of their patients would not be subject to the sales tax. However, a sales tax would be collected on any medicines or appliances that were sold to the patient by the physician. It was indicated that as soon as the State Department of Revenue had drafted its regulation that it would be circulated to members of the profession.

Correspondence from the local UMWA administrator, Asa Barnes, M.D., Louisville, which related to problems the Welfare Fund was having with repeat hospitalization of patients, was read. Doctor Barnes had asked for suggestions from the chairman of the Council and the president as to how this problem might be overcome. After discussion, it was agreed that the Association would be glad to cooperate in this problem, provided, however, that there could be full cooperation on all matters between the Association and the Fund, with respect to the Fund's program of medical care.

The Council heard correspondence read and listened to a discussion, relative to the appeal of a member of the Scott County Medical Society to the Council, relative to an alleged grievance. The Council then voted to hold a meeting to consider this problem at a later date to be set by the appropriate officers of the Association.

Governor's Bill Explained

Gaithel Simpson, M.D., chairman of the KSMA Committee on Medical Education and Economics, explained the responsibilities of the Association in carrying out that portion of the Governor's Reorganization Bill passed at the 1960 Legislature that deals with Article VII and the Medical-Care Program for the Indigent. Following the explanation of the provisions of the Bill and discussion, the Council thanked Doctor Simpson for his efforts. It then made nominations for the appointments to fill offices called for from the medical profession under the act.

The KSMA representative on the steering committee set up to organize the Kentucky Health Council, Carl Cooper, M.D., Bedford, reported on the progress that had been made in organizing said council.

The Kentucky Surgical Society and the Southern Surgical Association were officially thanked for their $1,000 and $200 contributions, respectively, to the McDowell House.

Help to School Teams Approved

The School Health Committee's request that a letter be sent to the Kentucky High School Athletic Association, stating the Association's willingness to help school teams in getting a physician, was approved.

The Committee on Public Information and Service was asked to re-study the matter of endorsing the operation of a statewide medical assistants group in Kentucky and to submit the matter to the 1960 meeting of the House of Delegates.

Mr. Joe Miller, AMA field service representative from Kentucky and former director of the Kentucky T. B. Commission, was introduced. Mr. Miller commented briefly on the growth of health insurance and legislative problems facing medicine.

As authorized by the 1956 session of the House of Delegates, the Journal is presenting a digest of the minutes of the March 30 meeting of the Council of KSMA.

Committee Reports

Rural Health Committee

Mitchell B. Denham, M.D., Chairman

Campbell House, Lexington **April 7, 1960**

The KSMA Rural Health Committee at this meeting reviewed the 1959 Rural Health Conference which was held at Bowling Green and attracted 154 registrants.

Planning for the 1960 Conference was initiated, with the concensus appearing to favor Morehead for the site. October 27 was set as the tentative date and "Health Careers for Our Youth" was chosen as the theme of the conference.

The Committee recommended to the Rural Health Council that membership in the Council be increased by including the Council of Southern Mountain Workers in Berea, the University of Kentucky College of Medicine and the Eastern Kentucky Planning Commission.

The American College of Obstetricians and Gynecologists, Chicago, has announced a Higher Education Loan Program (HELP) under which resident physicians may obtain loans up to $5,000 to help them through their specialty training period and early practice. HELP will start with a working fund of $36,000, contributed by ACOG and its district organizations. Further information may be obtained by writing to Donald F. Richardson, Executive Secretary, ACOG, 79 West Monroe Street, Chicago 3.

Industrial Medical Group Elects Dr. Rowntree

Gradie R. Rowntree, M.D., Louisville, was named president-elect of the Industrial Medical Association at the group's annual meeting in Rochester, N. Y., on April 27. He will assume the office in 1961.



Dr. Rowntree

Doctor Rowntree was first-vice president of the 4,000-member association the past year and has served twice on its board of directors. He was the first president of the Kentucky Industrial Medical Association which was organized last September and held its first annual meeting in April. Doctor Rowntree is chairman of the Louisville-Jefferson County Board of Health and is professor of occupational medicine at the University of Louisville School of Medicine.

The Rochester meeting attracted 2,300 physicians and others interested in occupational accidents and illness and preventive medicine for industrial workers, Doctor Rowntree said.

Cancer Center Gets $20,000 Grant

A $20,000 grant to the University of Louisville department of radiology by the Kentucky Division, American Cancer Society, was announced last month by Richard F. Grise, M.D., Bowling Green, division president. The money is to be used for salary purposes at the new cancer-treatment center planned in Louisville's Medical Center.

Estimated cost of the center is $250,000—half of which will come from the U. of L.'s development program and half from the Federal Government. The university recently raised $1,489,585 for the center and a new medical-dental research building.

Physical Therapist Joins Staff Of Health Department

Kentucky has a new consultant in physical therapy. Appointment of Joel Broida, on loan from the U. S. Public Health Service, was announced May 11 by Edwin Cameron, M.D., director of the Division of Chronic Disease Control, State Department of Health.

Working out of the Chronic Disease Division, Mr. Broida will be available to all county health departments in the state, Doctor Cameron said. For the first few months, he will give attention to the seven counties with Home Care Programs in their local health departments: Scott, Bourbon, Harrison, Owen, Clark, Mercer and Knott. These programs, sponsored jointly by the county health departments and county medical societies, are designed to aid patients confined to their homes.

Mr. Broida comes to Kentucky from the Public Health Service Hospital in Boston. In preparation for his new assignment, he visited Georgia to review that state's work with persons who have suffered strokes. He also studied the home care demonstration program in Person county, North Carolina.

Care Of Indigent Crippled Children Is Announced

The Kentucky Crippled Children Commission offers services to children whose parents are indigent or unable to pay total amount of care. Treatment is provided for types of crippling conditions, such as polio, congenital deformities, cerebral palsy, tuberculosis of the bone, osteomyelitis, scoliosis, flat feet, rickets and injuries causing orthopedic defects. Also provided is plastic surgery in cases of burns, cleft lips and cleft palates.

The commission holds regular clinics in centers in Louisville, Lexington, Covington, Paducah and Ashland. Field clinics are being scheduled in various parts of the state during the spring, summer and fall months. These clinics will be publicized through the local press, radio and television stations. Patients may attend the field or regular clinics in the various centers.

Referrals may be sent to Marjorie K. Smith, M.D., Medical Director, Kentucky Crippled Children Commission, 1405 East Burnett, Louisville 17.

AMA Contradicts Statement Of Nurses Group

The American Medical Association has issued a memo contradicting a news release of the American Association of Doctors' Nurses stating that the AMA would loan a part of its large collection of exhibits to the group's convention in Miami, June 23-26. "The American Medical Association has not loaned any exhibits to this group," the memo said.

The AMA explanation continued: "Originally known as the American Registry of Doctors' Nurses, this organization, which mailed its promotional materials from Marianna, Fla., was said to be in violation of the Nurses Practices Act in Florida in 1958 by the Attorney General in that state.

"The group moved to Washington, D. C. Last summer the Federal Trade Commission charged this group with misrepresenting itself as a nonprofit organization and with giving customers the means to misrepresent themselves as registered, graduate or licensed nurses. The organization changed its name to the American Association of Doctors' Nurses."

Jackson's Dr. Rypstra Honored

John B. Rypstra, M.D., Annville, Jackson county's only physician the past four years, has won public recognition for his medical ministry emanating from the Worthington Memorial Health Center. The Kiwanis Club and Woman's Club of Jackson County gave a banquet honoring him for his service to the community of some 10,000 persons.

A native of Muskegon, Mich., Doctor Rypstra came to Kentucky in July, 1949. In addition to his regular practice, he supervises care of patients in the campus infirmary at Annville Institute.

Fall PG Opportunities Included In New KSMA Listing

Following a statistical survey conducted in Kentucky by the KSMA's Committee on Postgraduate Education, programs are planned at different locations in the state for the fall of 1960.

Detailed information of these listings may be obtained through the new Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2. The telephone number is JUniper 7-7135.

PG offerings announced to date follow:

June

14 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

17-18 Kentucky and Indiana Chapters of the American College of Surgeons and the Kentucky Society of Anesthesiologists and corresponding anesthesiology organization of Indiana, joint meeting; French Lick, Ind.

20-24 "Postgraduate Course in Internal Medicine," sponsored by the American College of Physicians; Indiana University School of Medicine, Indianapolis; Medical Science Building, Room B-26. Registration fee: ACP members, $60; non-members, $80.

July

18 Joint meeting of the Sixth Councilor District and the TB Hospital, Glasgow, with scientific-paper presentation for general practitioners; TB Hospital, Glasgow.

19 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

27-29 "Postgraduate Course in Tumors—Diagnosis and Treatment"; University of Tennessee College of Medicine, Memphis.

August

16 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

25 Joint meeting (tentative) of the First and Third Councilor Districts, with scientific-paper presentation.

September

7-10 Postgraduate Course in "Heart Disease—With Emphasis On Newer Diagnostic Techniques—Medical and Surgical Management"; Cardiac Laboratory, Cincinnati General Hospital; limited to 75 persons; fee, $75.

20-22 KSMA Annual Meeting, Columbia Auditorium, Louisville.

20 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

26-27 Tennessee Valley Medical Assembly, Read House, Chattanooga; For information, contact Dr. Robert A. Waters, 109 Medical Arts Building, Chattanooga, Tenn.

13th District Meeting Draws 55

KSMA members from eight counties attended the afternoon and dinner meeting of the Thirteenth Councilor District at the Henry Clay Hotel in Ashland on April 21. Wives and other guests brought the attendance to 55, District Councilor Charles B. Johnson, M.D., Russell, reported.

The KSMA president, Irvin Abell, Jr., M.D., Louisville, was the dinner speaker. Scientific essayists were Edmund Pellegrino, M.D., professor and chairman of the Department of Medicine, University of Kentucky Medical Center, Lexington; William E. Copeland, M.D., Ohio State University Medical School, Columbus, and Michael L. Furcolow, M.D., chief of the Kansas City Field Station, Communicable Disease Center, Kansas City, Kan. Host group was the Boyd County Medical Society headed by John Hopkins Neyer, M.D., Ashland.

14th District Meets At Hazard

The annual afternoon and dinner meeting of the Fourteenth Councilor District was held at La Citadelle, Hazard, on April 20 with good attendance and interest, District Councilor William C. Hambley, M.D., Pikeville, reports. The Perry County Medical Society, headed by A. B. Pigman, M.D., Allock, was the host group. C. C. Rutledge, M.D., Hazard, was in charge of arrangements.

The KSMA president, Irvin Abell, Jr., M.D., Louisville, was the featured speaker. Scientific essayists were three Lexington physicians, Maurice Kaufmann, M.D.; Carl Fortune, M.D., and E. H. Ray, M.D.

County Society Reports

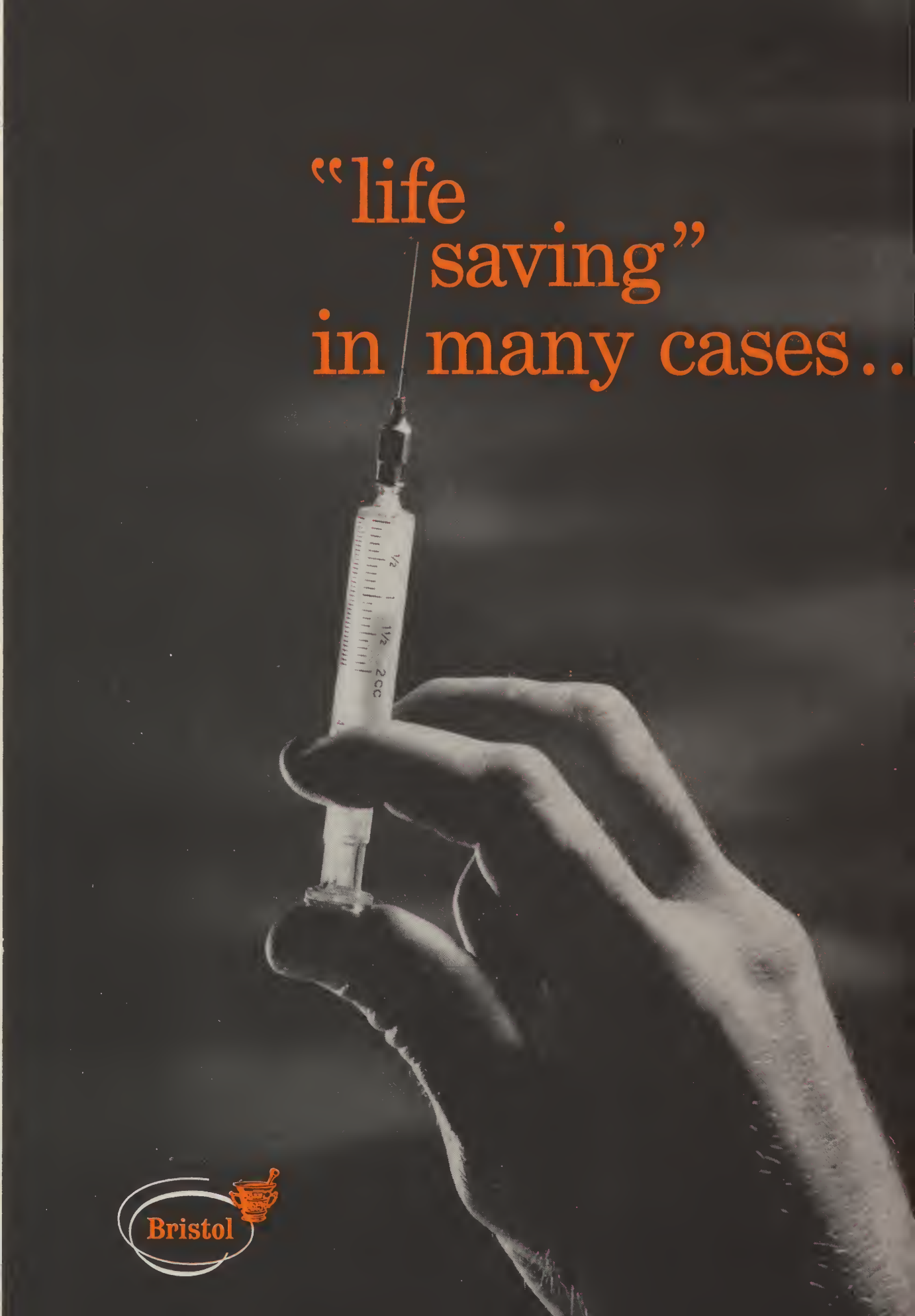
McCracken County

The proposed changes in the Constitution and Bylaws of the McCracken County Medical Society were read in their entirety at the April meeting. Action on the changes was set for the next meeting.

A report on the 10th Annual County Society Officers Conference in Owensboro on March 31 was made by Walter Johnson, M.D.

The program included a presentation, "Prepaid Insurance," by Kentucky Physicians Mutual, Inc., and Kentucky Blue Cross, Inc. J. Vernon Pace, M.D., presided and introduced the speaker, Ed McConnell, vice-president of Kentucky Physicians Mutual. A general discussion followed the address.

The 11th annual publication of "Reviews of Medical Motion Pictures" is now available on request from the Film Library of the AMA. This publication is prepared by the Division of Communications, Department of Medical Motion Pictures and Television, and contains reprints of all reviews published in The Journal of AMA during 1959.


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REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK

Positive Eight-Point Program For the Aged Announced By AMA*

Louis M. Orr, M.D., Orlando, Fla., president of the American Medical Association, issued the following statement on the Eisenhower Administration's Medical Care Plan for the Aged, which was announced in Washington on May 5:

The Administration proposal is based on the false premise that almost all persons over 65 need health care and cannot afford it. This is not a fact. The truth is that a majority of our older people are capable of continuing a happy, healthy and, in many cases, productive life. Of the more than 15 million persons in the nation over 65 years of age, only 15 per cent are on old age assistance. An undetermined number, although able to finance other costs, find it difficult to withstand the additional burden of the cost of illness.

It is for these people that something should be done. Neither the Forand advocates nor the Administration proposal are tailored to meet these problems.

OAA Liberalization Supported

Here is the AMA's positive eight-point program for the health care of the aged:

(1) The Needy Aged. These aged now receive health care through OAA programs. Here the need is for better organized medical care programs including improved preventive medical care;

(2) The Near-Needy. This is the group whose size is indeterminate, who can meet ordinary costs of living but cannot pay for health care costs. The AMA supports a state-administered program of federal grants-in-aid to the states for the liberalization of existing OAA programs so that the near-needy could be given health care without having to meet the present rigid requirements for indigency. A liberalized definition as determined locally would permit an expanded program and encompass the near-needy group;

Nursing-Home Improvement Urged

(3) Facilities. Better nursing-home facilities for the long-term care of the aged person, especially those over the age of 75, are the most urgent health care need before the nation today. The average age of nursing-home patients is 80, and their average duration of stay is two years. It is here that major improvement can be brought about. And supports federal programs for the provision of grants through the Hill-Burton mechanism to provide for new nursing home additions to existing hospitals.

For proprietary nursing homes the AMA supported the recently enacted amendment to the Federal Housing Act, providing for government guaranteed mortgage loans to proprietary nursing homes. AMA is also cooperating with the American Nursing Home Association and the American Hospital Association in an effort to bring about a rapid improvement in medical care provided in nursing homes;

(4) Voluntary Health Insurance. Health insurance and prepayment policies tailored to meet the needs of the aged for long-term nursing home care must be developed as rapidly as possible. Health insurers and the Blue Cross and Blue Shield Plans across the nation are already experimenting in this new area of coverage;

Home-Nursing Programs Developed

(5) Home Nursing Care. Care of the aged patient at home is psychologically, medically and financially desirable. Many programs to promote home nursing care are being developed.

Homemakers' services also provide opportunities for children caring for aged mothers or fathers to continue gainful occupation. They need to be expanded;

(6) Attitude Toward Aged. A basic change in attitude toward the aged person must be brought about. The person who reaches 65 has not suddenly become non-productive, and senescent. On the contrary, most persons over 65 are reasonably well and able to work. Increased productivity by eliminating compulsory retirement and permitting voluntary change of work is an essential part of the answer to the present problem;

Health Education Included

(7) Health Education. Many older persons are unaware of the need for continuing healthful nutrition and other practices that contribute to good health. Above all the "will to live" is essential to continuing health. Preventive medical measures instituted long before the age of 65 also can contribute materially to the promotion of good health after age 65;

(8) The Purchasing Power of the Dollar. One of the principal economic problems of the aged person in the last twenty years has been the constant and continuing erosion of the purchasing power of his pension benefits. Any government program to help the aged must be anti-inflationary and maintain the purchasing power of fixed pension and annuity benefits.

Sensible, economical health care programs for the aged that preserve freedom at the same time that they promote security must necessarily be limited to support for the needy aged and leave to voluntary, competitive, private enterprise, those activities needed to improve the health care of the rest.

**The above statement was issued by the American Medical Association, Chicago, on May 6, 1960.*

Dr. Brown Gets Tri-County Post

L. C. Brown, M.D., a native of Lexington, has been approved by the Boards of Health of Henderson, Union and Webster counties as director of their County Health Departments. He succeeds the late John C. Rogers, M.D.

A 1954 graduate of Northwestern Medical School, Doctor Brown practiced in Floyd county for two and a half years. He served as a lieutenant in the U. S. Navy for two years.

NEWS ITEMS

David M. Cox, M.D., Louisville, has been appointed a member of the National Foundation's Health Scholarship Committee for Kentucky, it is announced by Thomas M. Rivers, M.D., New York, the Foundation's vice-president of medical affairs. Doctor Cox is one of the vice-presidents of the Kentucky State Medical Association.

Richard D. Floyd, M.D., has joined the staff of the Lexington Clinic, Lexington. His specialty is cardiovascular, thoracic and general surgery. Born in Oakland Ky., Doctor Floyd received his medical degree from Yale University in 1952. He interned at Duke University Hospital, where he also was a resident for five years. He served in the U. S. Army as a captain in the Medical Corps from 1953-55.

Russell L. Hall, M.D., who has been in private practice of medicine at Wheelwright, has been appointed health officer of Floyd and Martin counties. Doctor Hall and his family will move to Prestonsburg after school is out. He is active in KSMA and KAGP organizational affairs.

William C. Mitchell, M.D., has started practice in Louisville in association with Morgan Colbert, M.D. His specialty is orthopedic surgery. A native of Louisville, Doctor Mitchell was graduated from the University of Louisville School of Medicine in 1952, interned at St. Joseph Infirmary, and practiced medicine at Cloverport from 1953 to 1956. The next four years he was a resident at Mayo Clinic and Foundation, Rochester, Minn. He served in the U.S. Army from 1943 to 1946.

WASHINGTON NEWS DIGEST

(Continued from Page 678)

would be "staggering." He said the Administration could have done better by proposing "full deductions for taxes for any amount spent for medical care of anyone" and for full costs of health plans by either an individual or corporation.

In endorsing the Administration's plan, Vice President Nixon charged the Forand-type proposals backed widely by Democrats would "open the door for socialized medicine." He said:

"The Forand bill and similar plans would set up a great state program which inevitably would head in the direction of herding the ill and elderly into institutions whether they desired this or not. Such a state program would threaten the high standards of American medicine."

Sen. Pat McNamara (D., Mich.), chairman of the Senate Subcommittee on Problems of the Aged, headed a group of 16 Senate Democrats who sponsored legislation that would provide hospitalization and medical care for virtually all the nation's older persons.

The co-sponsors included three avowed candidates for the Democratic nomination for president—Sens. Hubert H. Humphrey (Minn.), John F. Kennedy (Mass.) and Stuart Symington (Mo.).

Cost of the McNamara legislation was estimated at $1,578,000,000 a year. This would be financed by a one quarter per cent increase in the Social Security tax and 370 million dollars from general tax money.

In Memoriam

M. H. MATHEWSIAN, M.D.
Louisville
1882 - 1960

Mehron H. Mathewsian, M.D., 78, retired Louisville physician, died April 11 at Veterans Hospital, Lake City, Fla. Burial was in Cave Hill Cemetery, Louisville.

A native of Turkey, Doctor Mathewsian came to the United States in 1899. He received his medical degree from the old Louisville Medical College in 1914 and maintained an office in the Fincastle Building, Louisville, for many years. At one time he was chief medical officer for the Louisville & Nashville Railroad. Doctor Mathewsian was a veteran of World War I.

CLEVES RICHARDSON, M.D.
Louisville
1890 - 1960

Cleves Richardson, M.D., who practiced medicine in Louisville for 44 years, died April 20 at Jewish Hospital, Louisville, at the age of 69. He was a well known sports enthusiast and served as physician for visiting athletes.

A native of Shelbyville, Doctor Richardson was graduated from the Jefferson School of Medicine, Philadelphia, in 1913. After interning in New York, he set up practice in Louisville in 1916. He was an Army captain during World War I. Doctor Richardson was an emeritus member of KSMA.

D. Y. RAGAN, M.D.
Cold Spring
1892 - 1960

David Yandell Ragan, M.D., Cold Spring physician, died April 13 at Booth Hospital, Covington. He was 68.

The son of a physician, Doctor Ragan practiced in the same office used by his father, the late Dr. George W. Ragan. Since his father's death in 1937 he had cared for the children at St. Joseph Orphanage and the residents at the Campbell County Home. Doctor Ragan was a 1920 graduate of the old Louisville Medical College.

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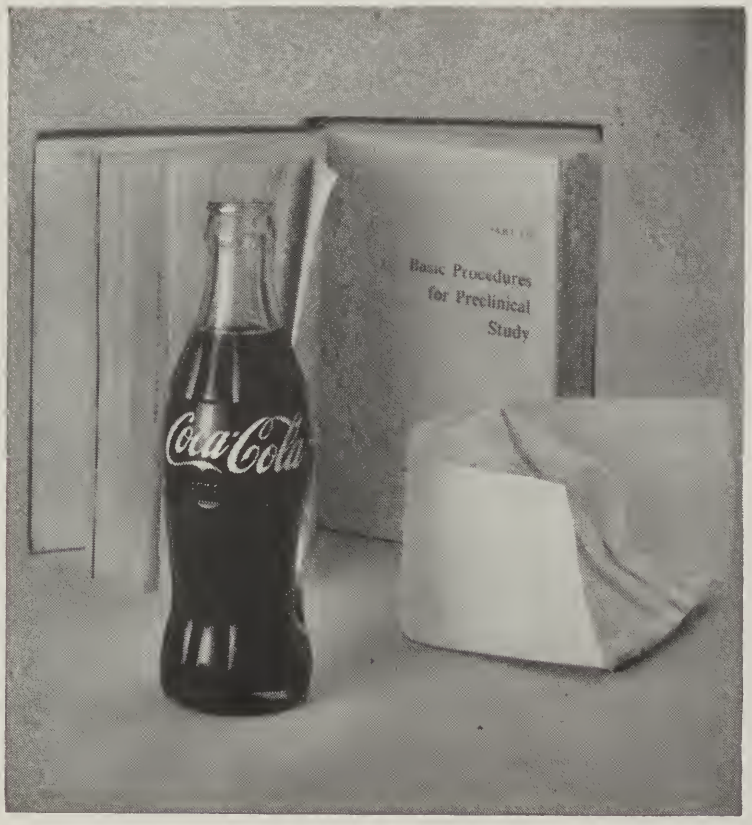
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CLINICAL AUSCULTATION OF THE HEART: Samuel A. Levine, M.D., and W. Proctor Harvey, M.D., published by W. B. Saunders Company, Philadelphia, 1959; 657 pages; price, $11.

For the presentation of this second edition of their textbook the authors have gathered together numerous additional auscultatory phenomena. By the demonstrations of heart sounds and murmurs they have shown once again the value of phonocardiography in the teaching, learning and understanding of cardiac auscultation.

The authors have chosen to concentrate on clinical auscultation, but the anatomic and physiologic facts which are essential to rational interpretation are adequately described. In many cases the patients were studied by means of cardiac catheterization. The therapeutic approach to each problem is briefly outlined, but due to the broad scope of the book is not complete.

The discussion of the genesis of heart sounds and murmurs is most informative and stimulating. The description of the characteristic auscultatory findings in acquired and congenital heart disease is clearly written and well supplied with illustrations which clarify the part under discussion.

The authors stress the fact that phonocardiography should not be viewed as a diagnostic technique but a graphic presentation of sounds for permanent records and teaching. In all instances the authors demonstrate the arrhythmia and extra sounds and state explicitly those cases in which no treatment is indicated. The book is recommended to anyone interested in the bedside management of heart disease.

D. David, M.D.

A TEXTBOOK OF MEDICINE: edited by Russell L. Cecil, M.D., Sc.D., and Robert F. Loeb, M.D., Sc.D.; published by W. B. Saunders Company, Philadelphia and London; 1,665 pages; price, $16.50.

The 10th edition of Cecil & Loeb's *A Textbook of Medicine* is warmly commended. The format of the old standby has remained the same, but recent important information, both clinical and experimental, has been added. This is true especially on the section on Diseases of the Ductless Glands, where numerous important advances have been made in the past several years since the publication of the last edition of the textbook.

The contributors are illustrious and, being experts in their respective fields, write with authority and precision.

Since this textbook covers the whole field of internal medicine, it is not to be expected that each disease entity be dealt with in minute details. Classical references, however, are available at the end of each section for interested students and physicians. For a standard textbook and general reference, Cecil & Loeb remains to be one of the best.

The foreward, "Patient-Physician Communication," written by Dana W. Atchley, is appropriately placed and should be carefully read and digested by every medical student and practitioner alike.

Samuel H. Cheng, M.D.

A DOCTOR'S LIFE OF JOHN KEATS: by Walter A. Wells, M.D.; published by Vantage Press, New York, Washington and Hollywood; 247 pages; price, $3.95.

In this rambling and digressive volume, Dr. Walter Wells has attempted to reconstruct the medical history of John Keats, to recount Keats' personal connection with the medical profession, and to account for such aspects of Keats' personality as his neurotic tendencies and his genius on the basis of his medical history and his environmental influences.

The author has found himself seriously hampered by the lack of objective data on which to base his interpretation of the life of the poet. He has attempted to make up for the lack of specific verifiable information by the introduction of many types of irrelevant discussion and speculation. For example, he ekes out the meager account of the early environment in which Keats developed by drawing sentimental teleological analogies from nature, by indulging in a somewhat meandering discussion to the effect that bad environment does not prevent the development of outstanding qualities, and by illustrating the simplest statements of self-evident fact by lengthy quotations, the only purpose of which seems to be the demonstration of the author's acquaintance with English literature.

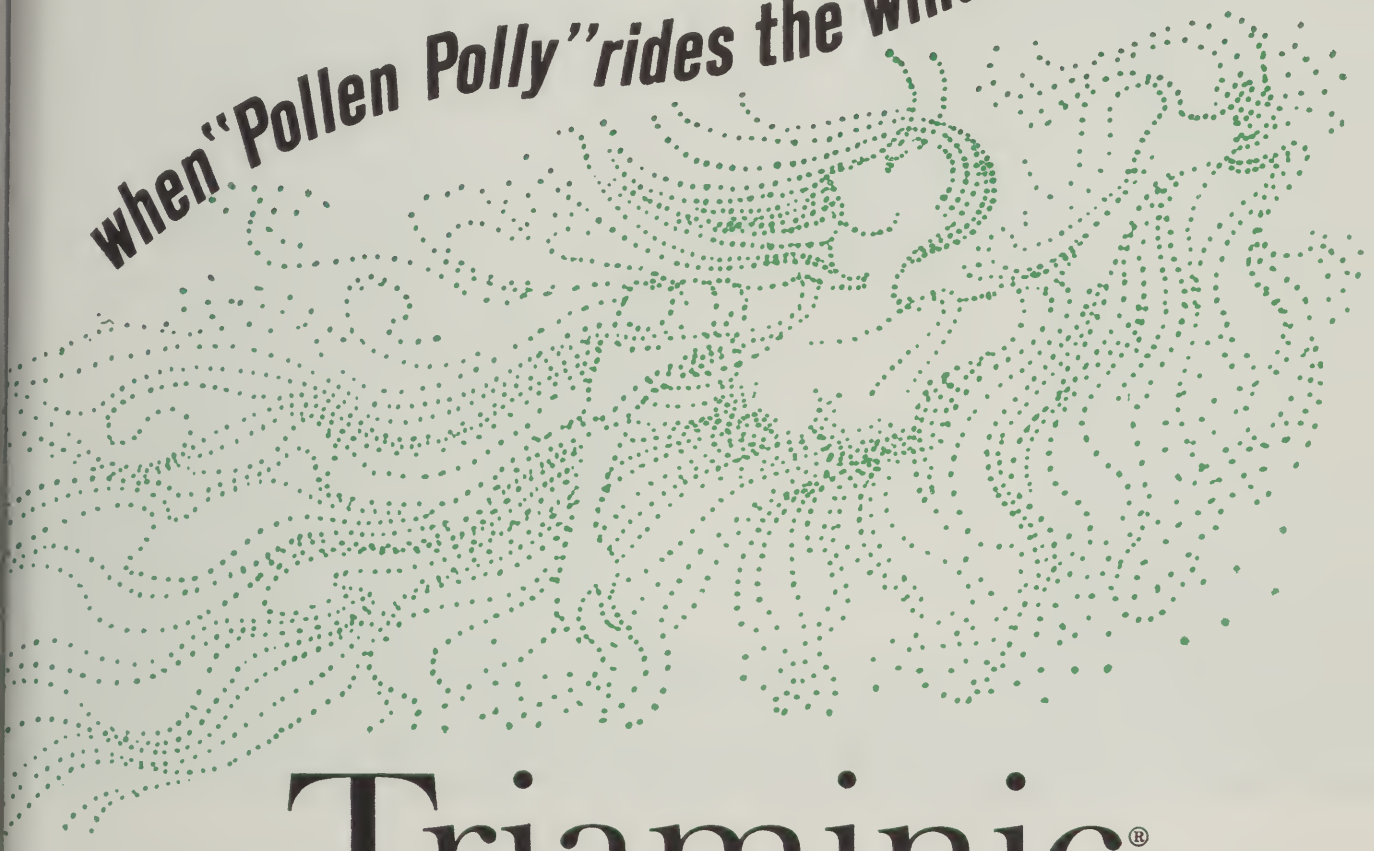
Imbedded in the pseudo-biography of Keats are numerous subsidiary biographies of various contemporaries of Keats, whose relevance to his own life is tangential, to say the least. For instance, the details of the criminal record of a notorious murderer are recounted for no more cogent reason than that the individual in question was enrolled at Guys Hospital at the same time as Keats.

For page after page, Doctor Wells indulges in fanciful reconstructions of the medical life of the period. The mere mention of a dissecting room launches the author in a disquisition on the history of dissection. A typical illustration of this method can be specifically cited: in the discussion of Keats' career at Guys Hospital as a surgeon's dresser and dissecting room assistant, the author states: "As Keats has told us

(Continued on Page 747)



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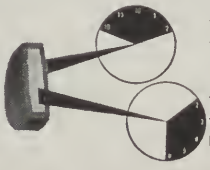
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References: 1. Fabricant, N. D.: E. E. N. T. Monthly **37**:460 (July) 1958. 2. Lhotka, F. M.: Illinois M. J. **112**:259 (Dec.) 1957. 3. Farmer, D. F.: Clin. Med. **5**:1183 (Sept.) 1958. 4. Fuchs, M.; Bodi, T.; Mallen, S. R.; Hernando, L., and Moyer, J. H.: Antibiotic Med. & Clin. Ther. **7**:37 (Jan.) 1960. 5. Halpern, S. R., and Rabinowitz, H.: Ann. Allergy **18**:36 (Jan.) 1960.

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Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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IN THE BOOKS

(Continued from Page 743)

nothing of his experience, let us turn to the memoirs of the great French composer Hector Berlioz—who, as it happened, was studying medicine at about the same time, in Paris—for a comparable picture." Berlioz' description of a dissecting room is then quoted *in extenso*.

When the author applies himself to the reconstruction of Keats' medical history, he is once again handicapped by a lack of data. He is free to admit that it is not possible to make precise clinical diagnoses from symptomatic evidence alone, such as is scantily available in Keats' case, but this does not prevent him from an elaborate discussion of the probable clinical diagnosis applicable to the poet. Since Keats suffered from pulmonary tuberculosis, Doctor Wells regales the reader with biographies of Augenbrugger and Laennec, the pioneers of auscultation of the chest. Specific passages from the poet's works are quoted in defense of a vague diagnosis of "melancholia."

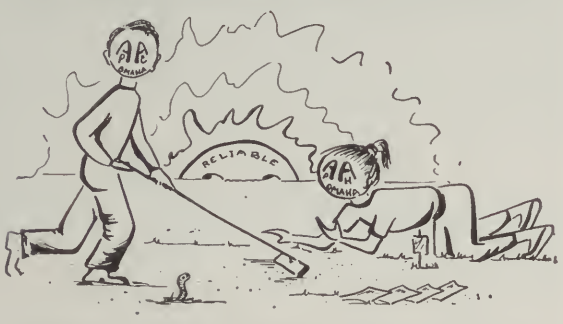
A chapter intriguingly entitled "The Truth About Keats' Love Life" provides nothing more than a few direct quotations in support of the notion of Keats' misogyny, together with a fanciful analysis of the connection between Keats' organic illness and his unhappy love affair with Fanny Brawne.

While much of the author's discussion is more to be criticized for irrelevance than for inaccuracy, he occasionally permits himself to commit an error of fact. For example, on page 94, Semmelweis is erroneously said to have been present at the autopsy of the pathologist Kolletschka, whereas it is well known that at this time Semmelweis was on vacation to Italy.

The final section of the book is devoted to a rambling pseudo-philosophic speculation on the mystery of genius considering the roles of heredity, insanity, inferiority complex and other similar influences. Here again the connection of this discussion with the ostensible subject of the book is tenuous in the extreme. Perhaps the disconnected effect of the book is best explained by reference to the author's preface, in which it is stated that the book was not originally planned as such, but is rather the outcome of the author's hobby of making contributions to the medical literature consisting of biographical sketches of doctors of eponymic fame, and brief articles related to the health history of celebrated men.

It is difficult to know for whom such a book as this is intended. Factual and critical writings regarding Keats have been numerous, and most of the scholarly efforts in this field are far superior to Doctor Wells' contribution. On the other hand, readers with a specific interest in the medical history of Keats will have to rummage through a great deal of chaff in order to encounter a few grains of wheat. Taken as a whole, the book illustrates the fallacy of expanding to book length subject matter best suited for treatment in a brief monograph.

Douglas M. Haynes, M.D.



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The Net Worth Method Of Determining Taxable Income

YOU'VE read numerous times that Joe Doe has been charged with evasion of Federal Income taxes over a period of years and has been or will be tried in Federal Court on these charges. Such a suit in Federal Court is for the purpose of establishing fraud and has nothing to do with the deficiency in taxes.

There are two classes of penalties provided by the statutes: civil and criminal. The civil penalty is added and assessed as a part of the tax, whereas criminal penalties are enforceable only by suit or prosecution.

Forgetting the civil penalty and concentrating on the criminal aspects of attempting to evade or defeat tax, we find this is punishable by a fine up to $10,000 or imprisonment up to five years, or both. This is the type of federal case we will be referring to in this article.

Assume that upon examination of a taxpayer's records by an Internal Revenue Agent, there is evidence of fraud and an indication that the proper tax has not been paid. This suspected omission may not stand out as any one particular item, but the Agent is suspicious due to the large amount of assets owned by the taxpayer in relationship to reported taxable income over a period of years.

With no specific or glaring omission of income, how then can the correct taxable income be computed?

The most common way is by using The Net Worth Method. Other means are by analyzing bank deposits and reconciling these deposits to reported or taxable income and on down to checking on specific items. The bank deposit method boils down to an actual verification or source of all deposits going into a taxpayer's bank account.

Let's examine The Net Worth Method of computing taxable income. First, net worth means the total value (cost) of all your assets minus any liabilities. These assets minus any liabilities will give you the net worth or equity of any individual or other business. A balance sheet is merely a net worth statement. This method of determining taxable income can be best illustrated by the following example.

ASSETS	12-31-55	12-31-59
Cash on hand in banks	$2,500	$4,700
Stocks — Bonds	11,500	25,000
Real Estate	24,000	42,300
Interest in ABC Loan Company	17,000	30,000
Other Assets	21,000	32,000
	$76,000	$134,000
LIABILITIES		
1st National Bank— Notes Payable	26,000	34,000
Net Worth	$50,000	$100,000
Increase in Net Worth in 4-year period		50,000
Plus money spent for living expense, taxes, 4 years @ $10,000		40,000
Increase in Net Worth plus other expenditures		90,000
Taxable income reported over 4-year period		50,000
Shortage in income reported		$40,000

Following the above illustration through, you will notice that in a four-year period the net worth of Joe Doe has increased exactly $50,000. To this increment in net worth, we have to add what Joe Doe and his family have spent for living expenses, insurance premiums, taxes and other items. For purpose of our illustration we have estimated this to be $40,000 for a four-year period. This means that enough income should have been reported to justify the increase in net worth along with those funds that have been expended that will not show any tangible values.

Such is not the case here, for theoretically Mr. Doe has failed to report $40,000 worth of taxable income for federal tax purposes. The Agent is going to be curious as to how this unreported income came into the taxpayer's possession. Assuming the above balance sheet is correct and there have been no inheritances, gifts, and other non-taxable receipts, it is very probable that Mr. Doe is going to find himself in the position of trying to avoid criminal prosecution and penalties.

With good records and sound accounting advice, Mr. Doe might have avoided the "Net Worth" pitfall. Certainly, in the long run it could have saved Mr. Doe much mental anguish and money.

William E. Rudd

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Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

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- does not produce ataxia, change in appetite or libido
- does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
- does not impair mental efficiency or normal behavior

for the tense and nervous patient



Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Generically and under the various brand names by which it is distributed, meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

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Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; or as MEPROTABS*—400 mg. *unmarked*, coated tablets.

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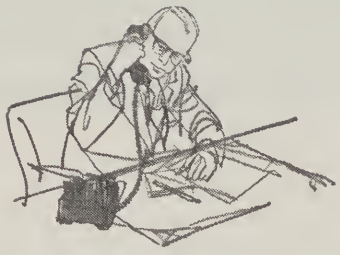
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when that early Monday morning telephone call is from a weekend do-it-yourselfer

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now...there is a way to prompt, dependable relief of back distress

the pain goes while *the muscle relaxes*

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From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



CASE #48: This patient was a 38-year-old white married gravida 3 para 2 whose last menstrual period was 12/10/57. She was expected to deliver 9/17/58. Her past history was significant since she had convulsions and temporary blindness with her first pregnancy 18 years ago. She consulted her physician with this pregnancy in her fourth month.

For the first 12-15 hours postoperatively the patient's blood pressure was in the range of 120/80, but then her pressure gradually began to rise and nausea and vomiting ensued.

Her condition suddenly grew worse, she developed respiratory distress, and died. Permission for post-mortem examination was not obtained. The attending physician thought that she demonstrated signs and symptoms of increasing

	Month of Pregnancy										
	1	2	3	4	5	6	7	8		9	
								1	2	3	4
Blood Pressure				124/80	116/90	120/78	120/78	130/84	172/106	105/80	116/104
Weight				180	182	185	190	201½	205½		219½
Urine								100mg	100mg	30mg	100mg

VDRL non-reactive 3/6/53

Her present prenatal course was uneventful and uncomplicated until July, the seventh month of pregnancy, when she began to have excessive weight gain, edema and albumin in the urine. She was placed on Diuril 0.5 gm., b.i.d., and a low salt diet in early August. She made a good initial response but had a gradual increase in edema, albuminuria, hypertension and weight gain.

On August 25, she had a sudden onset of preeclamptic symptoms including gastrointestinal symptoms. She was hospitalized and treated with $MgSO_4$, barbiturates, bed rest and Serpasil, dosage not given. Her blood pressure dropped from an unstated reading and her general condition improved, although the eye grounds showed progressive evidence of papilledema. Consultation was obtained and cesarean section was recommended. No mention was made of vaginal examination to determine the condition of the cervix.

A classical cesarean section was done August 30 without complication, and she was delivered of a male infant weighing 5 lbs. 1/4 ozs. cerebral edema until the final episode of respiratory distress and sudden death. The exact cause of death was unknown. On the death certificate the cause was stated to be cerebral edema due to severe preeclampsia due to toxemia of pregnancy.

Comments

The committee questioned the management of this case. From the information supplied, it would seem that a multipara who was only 2-3 weeks from term by menstrual history could have been successfully induced and delivered vaginally during the period the toxemia was being treated. If the cervix was initially unfavorable, repeated daily pitocin infusions could have been tried until the cervix was sufficiently dilated to permit artificial rupture of the membranes. The committee thought that the cause of death in this case might have been a massive pulmonary embolus.

The case was considered to be a direct obstetrical death with possible preventable factors. It illustrates the need of obtaining an autopsy.

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A new cancer detection film, entitled "The Cancer Detection Examination," is now available for showing to qualified professional groups, Eli Lilly and Company of Indianapolis announces. The film was produced from a video tape of a closed-circuit telecast in cooperation with the American Cancer Society, New Jersey Division, Inc. It presents Emerson Day, M.D., director of the Strang Clinic, Memorial Center for Cancer and Allied Diseases, New York City, demonstrating the presymptomatic detection of cancer through simple office procedures. The black-and-white, 16mm. motion picture requires a showing time of 46 minutes. Requests for booking must come from qualified physicians' groups and should be made at least 30 days before meeting dates. Address Eli Lilly and Company, Indianapolis 6, Ind.

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PUBLIC HEALTH PAGE

Fluoridation*

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health Commonwealth of Kentucky*

WATER-BORNE fluorides have been under scrutiny since shortly after 1901, when Doctor Eager of the United States Immigration Service first reported on mottled enamel present in the mouths of some Italian immigrants.

From this first known scientific report on mottled enamel evolved the study of the condition and discovery of its endemic character. Dr. Frederick McKay pursued this study in Colorado Springs and hypothesized that an agent in the water was responsible for the condition. Doctor McKay also was one of the first to notice the correlation between endemic mottled enamel and the low prevalence of dental caries.

With the perfection of scientific methods of microdetermination of trace amounts of fluorides in water in 1933 and the development of the D M F index to measure caries experience in 1934, the studies of communities using water-borne fluorides reached full stride. Dr. H. Trendley Dean and others demonstrated that an optimum concentration of around 1 mg./liter (1 ppm) of fluorides in water produced a decrease in dental caries, but practically no mottled enamel.

Numerous Studies Made

From this point, extensive epidemiological studies were carried out in numerous fluoride areas in the United States. Morbidity and mortality figures were accumulated in fluoride and in non-fluoride areas. The conclusions from the numerous studies were:

1. That people using water containing optimum or near optimum concentrations of fluorides had approximately 60 per cent less dental caries than people in like communities drinking waters that were practically fluoride-free.

2. These people suffered no ill effects. In fact, studies showed that people drinking water containing much higher concentrations showed no ill effects other than mottled enamel.

After these studies of people who had been drinking fluoride-containing waters, there was no real question of its safety. The question in the minds of the scientists was whether or not this condition could be produced by fluoridating the water. They hypothesized that it could. After the notable Newburgh-Kingston and similar studies this is no longer hypothesis, but scientific fact.

Dental Caries Reduced 60%

The proven facts are these: Fluoridated water at 1 ppm harms no living thing; it produces a 60 per cent or better reduction in dental caries and a reduction in the sequela of dental caries; it is one of the cheapest public health measures that a community can institute, and it interferes with no home or industrial process.

It is estimated that for each dollar invested in water fluoridation approximately $56 savings are realized in dental needs. Fluoridation of a communal water supply means the prevention of preventable infection and a reduction of needless suffering on the part of the people, yet it taxes the understanding to realize that millions of people are being denied this health benefit.

In Kentucky some 40 communities are fluoridating their water supplies at the present time; but the fact is, at least twice as many communities should be realizing this benefit.

The health professions have not been as vocal in informing our people as the quasi-health people, quacks and publicity seekers have been in misinforming them.

Recently fluoridation referenda have lost in communities in Kentucky because these people have used such scare tactics as laying dead rats and fluoride cans outside the polling places. We seem to tolerate this type of action without getting aroused.

Help of Physicians Needed

Every recognized health organization has endorsed fluoridation, but these endorsements mean nothing unless the members of these organizations carry the message to the people of their communities.

Fluoridation is very meaningful in Kentucky because present dental manpower does not reach all of the people, and many in our Commonwealth could not purchase dental care if it were readily available.

Each member of the medical and allied professions should pledge to do his utmost in the future to combat the work of the fluoridation opponents, and to bring sound, scientific information to the people about the benefits of fluoridation. When the people are aware of the true facts, they will fluoridate all of their communal water supplies.

Prepared by E. B. Gernert, D.M.D., M.P.H., Associate Director, Division of Dental Health, State Department of Health.

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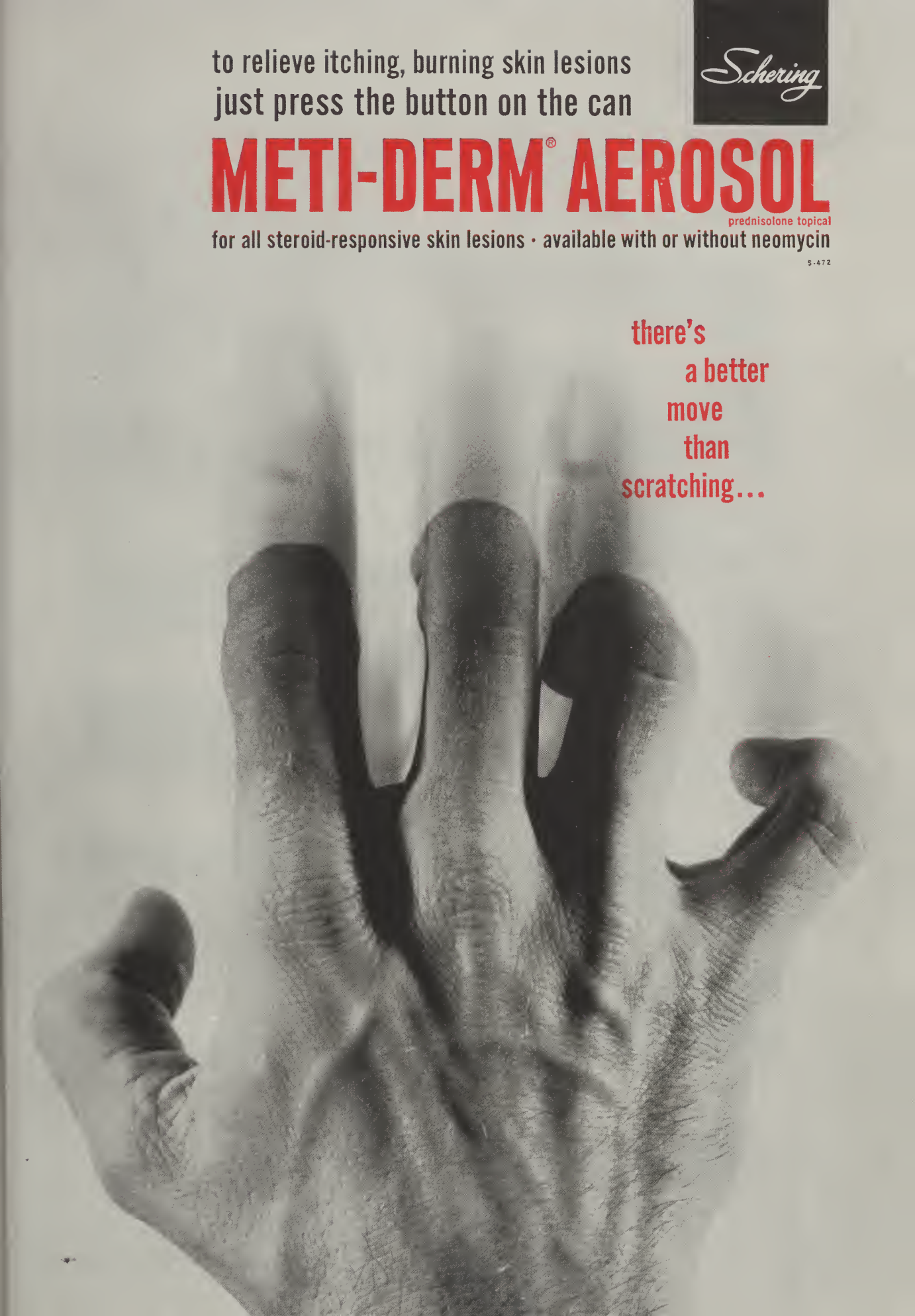
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Columbia Auditorium — **Louisville, Kentucky** — **September 20, 21, 22**

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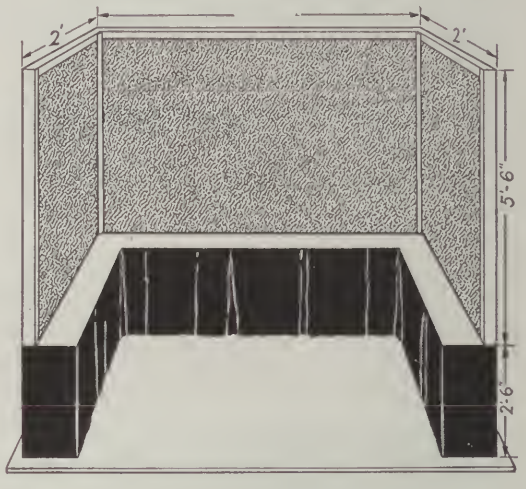
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Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

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4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

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The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

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1. A. M. A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) equivalent to 0.16 Gm. (2½ gr.) Theophylline U.S.P. Supplied: Bottles of 1 pint and 1 gallon.

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*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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Diagnostic Quandaries

Colitis? Gall Bladder Disease?
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A DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.[1]

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica*. In 15 of these subjects, nine stool specimens were required to establish the diagnosis.[2]

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.[3]

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1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. *6*:1821 (Dec., 1955).

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. *9*:897 (June, 1958).

*U.S. Pat. No. 2,864,745

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	Term
W. Vinson Pierce, 33 East 7th Street, Covington	Jan. 1, 1960-Dec. 31, 1961
J. Vernon Pace, 333 Broadway, Paducah (Alternate)	Jan. 1, 1960-Dec. 31, 1961
Robert C. Long, 806 Heyburn Building, Louisville	Jan. 1, 1959-Dec. 31, 1960
George P. Archer, Prestonsburg (Alternate)	Jan. 1, 1959-Dec. 31, 1960

COUNCILORS

		Term Expires
First District	Hugh L. Houston, Murray	1962
Second District	Walter L. O'Nan, 700 North Elm Street, Henderson	1961
Third District	Ralph D. Lynn, Elkton	1962
Fourth District	Dixie E. Snider, Springfield	1962
Fifth District	Carlisle Morse, 3612 Lexington Road, Louisville	1960
Sixth District	John P. Glenn, Russellville	1960
Seventh District	Wyatt Norvell, New Castle	1961
Eighth District	Norman Adair, 722 Scott Street, Covington	1960
Ninth District	J. M. Stevenson, Brooksville	1961
Tenth District	Douglas E. Scott, 2101 Nicholasville Rd., Lexington (Interim Appointee)	
Eleventh District	Joe M. Bush, Mt. Sterling	1960
Twelfth District	Thomas O. Meredith, Harrodsburg	1962
Thirteenth District	Charles B. Johnson, Russell	1961
Fourteenth District	William C. Hambley, Pikeville	1962
Fifteenth District	Keith P. Smith, Corbin	1960

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The Holiday Inn

***SPRINGFIELD, MISSOURI**
Sunday, June 26, 1960
The Holiday Inn

***ROANOKE, VIRGINIA**
Saturday, July 16, 1960
The Hotel Roanoke

***SANTA ROSA, CALIFORNIA**
Friday, September 16, 1960
The Flamingo Hotel

***KANSAS CITY, KANSAS**
Friday, September 23, 1960
Battenfeld Memorial
Auditorium

HOUSTON, TEXAS
Saturday, September 24, 1960
The Shamrock Hilton Hotel

DEFIANCE, OHIO
Wed., September 28, 1960
Defiance College

PHILADELPHIA, PENN.
Sunday, October 16, 1960
The Sheraton Hotel

***HARTFORD, CONNECTICUT**
Thursday, October 20, 1960
The Statler Hotel

***GREAT FALLS, MONTANA**
Saturday, October 22, 1960
The Rainbow Hotel

ROCHESTER, NEW YORK
Wednesday, October 26, 1960
The Manger Hotel

CHARLESTON, WEST VIRGINIA
Sunday, October 30, 1960
The Daniel Boone Hotel

SIOUX FALLS, SOUTH DAKOTA
Tuesday, November 1, 1960
The Sheraton-Cataract Hotel

***CHARLOTTE, N. CAROLINA**
Thursday, November 3, 1960
The Hotel Charlotte

***CLEVELAND, OHIO**
Wednesday, November 9, 1960
Pick Carter Hotel

***SOUTH BEND, INDIANA**
Friday, November 18, 1960
The Pick-Oliver Hotel

WESTCHESTER COUNTY, N. Y.
Wednesday November 30, 1960
Westchester Country Club

ST. PETERSBURG, FLORIDA
Saturday, December 3, 1960
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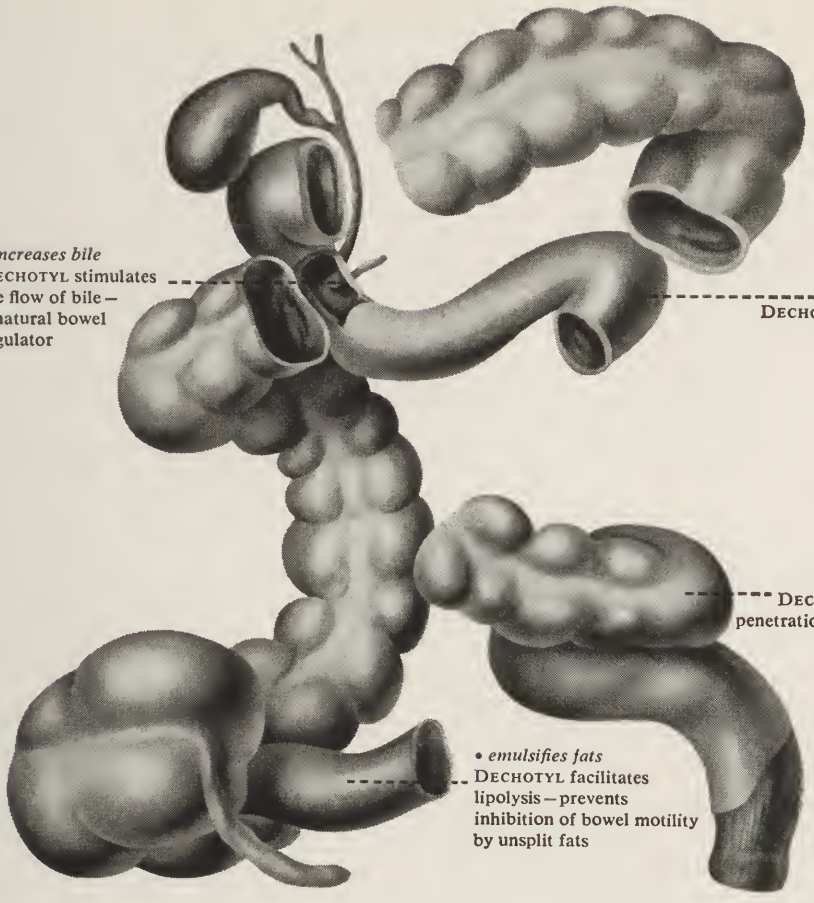
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The JOURNAL of the Kentucky State Medical Association

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KENTUCKY STATE MEDICAL ASSOCIATION
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JULY 1960 · VOLUME 58 · NUMBER 7

one child has epilepsy...

even her companions might not know—if her seizures are controlled with medication

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Bibliography: (1) Scott, J. S., & Kellaway, P.: *M. Clin. North America* 42:415 (March) 1958. (2) Ganoug, L. D., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, pp. 98-102. (3) Bray, P. F.: *Pediatrics* 23:151, 1959.

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CLINICAL REMISSION
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MESSAGE FROM THE PRESIDENT

Together We Stand

It may come as a shock to some physicians to realize that the future of private medical practice no longer depends solely on the professional competence of doctors. While there is little criticism of the professional ability, conduct or devotion of individual physicians, there is a rolling, relentless surge of discussions relating to the cost of health care and the means for meeting such costs.

The doctor may contribute his time, his energy and his skill; but this represents less than one half of an illness' total cost. The hospital bill must be met, for the hospital has a cost for the maintenance of each bed. This expense depends upon such major factors as utilities, food, lay and professional services, repairs to and replacement of equipment, plant maintenance, and administration. Today, a hospital, so as to remain solvent, is forced to insist upon prompt payment of patients' bills.

Since the American Public lives on consumer credit and possesses little or no dollar saving, it is the plain duty of every physician who believes in the superiority of private medicine to promote the extension of voluntary health insurance. If medicine is in the future to enjoy freedom from lay interference and the public is to enjoy freedom in choice of physician, the financing of health care cost by most individuals must be a voluntary private function and not an involuntary government function.

An involuntary government function and socialized medicine are synonymous terms; and our own Supreme Court has already written the opinion that, "It is scarcely lack of due process for government to regulate that which it subsidizes." Without private medicine there would be no need for voluntary health insurance; and without voluntary health insurance there could be no private medical practice.

Louis Abell Jr.

in arthritis and allied disorders

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brand of phenylbutazone
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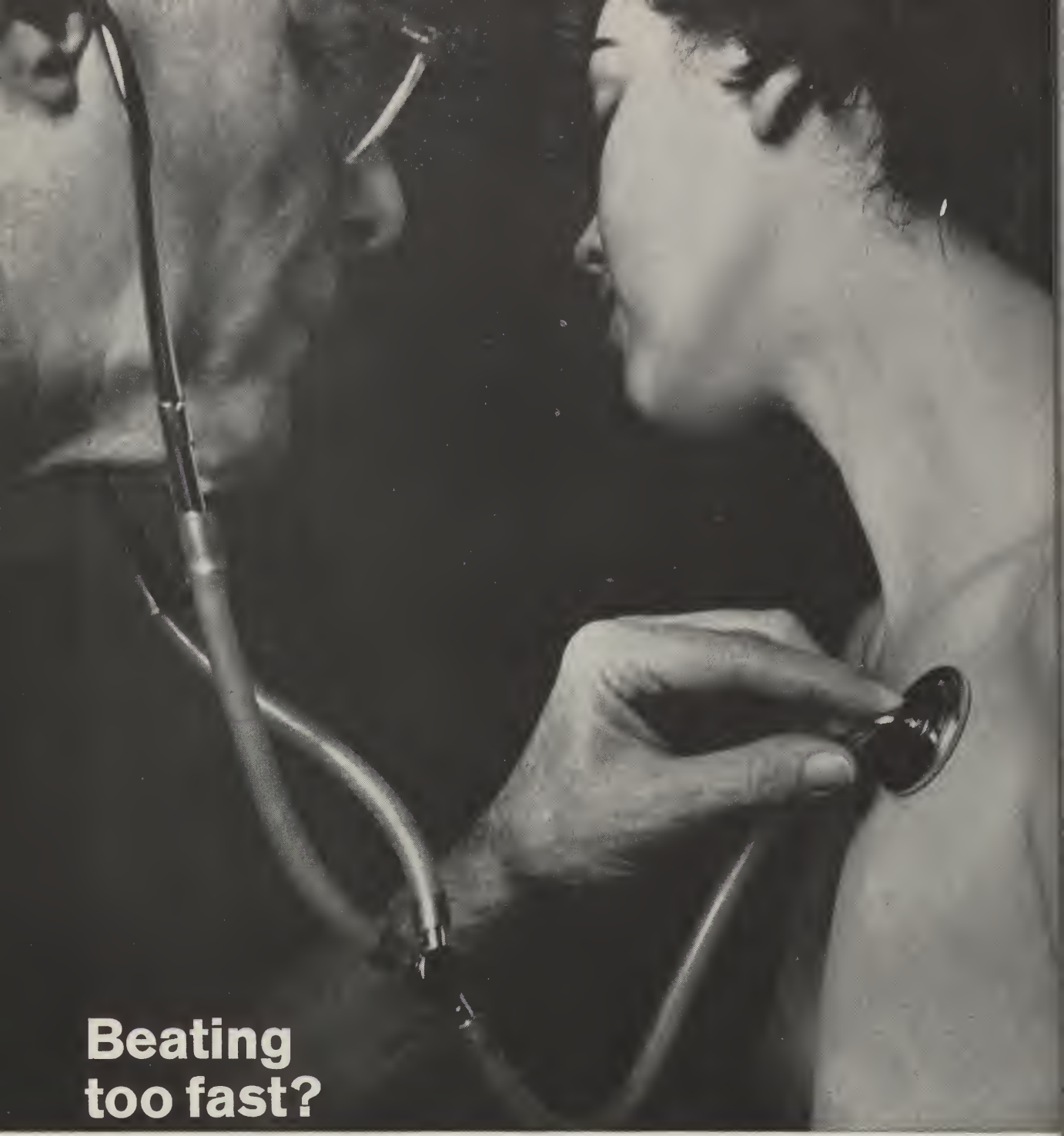
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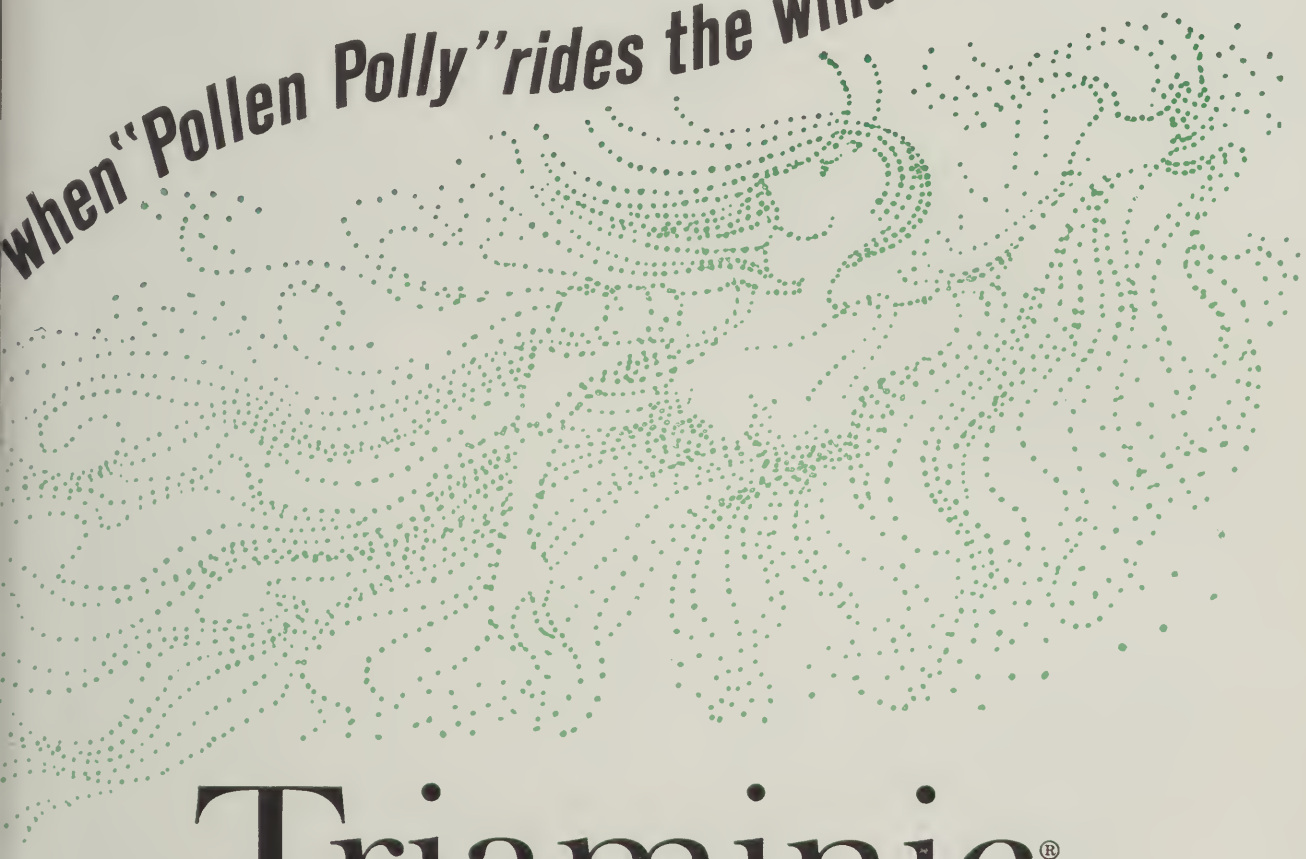
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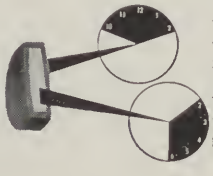
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REFERENCES: **1.** Gifford, R. W., Jr., *In* Hypertension, ed. by J. H. Moyer, Saunders, Philadelphia, 1959, p. 561. **2.** Moyer, J. H.: *Ibid.* p. 299. **3.** Brodie, B. B.: *In* Hypertension, Vol. VII, Proceedings Council for High Blood Pressure Research, Am. Heart Assn., ed. by F. R. Skelton, 1959, p. 82. **4.** Wilkins, R. W.: Ann. Int. Med. 50:1, 1959. **5.** Freis, E. D.: *In* Hypertension, ed. by Moyer, *op. cit.*, p. 123. **6.** Ford, R. V., and Nickell, J.: Ant. Med. & Clin. Ther. 6:461, 1959. **7.** Fuchs, M., and Mallin, S. R.: Int. Red. Med. 172:438, 1959.

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Blue Shield to Restudy Standard Benefits

THE physicians of Kentucky can and should look with pardonable pride on the accomplishments of their Blue Shield Plan. In eleven years during which Kentucky Physicians Mutual, Inc., has been in operation, it has greatly helped many thousands of patients in meeting the costs of illness through the prepayment mechanism.

In spite of the constant rise in living costs which has been taking place since 1949, Kentucky Physicians Mutual has been able to avoid any increase in the premium rate on its standard contract, and at the same time has not only maintained the level of its indemnity payments for most services rendered, but has increased these amounts in a number of instances. Some procedures, which were not included in the original schedule of benefits, have subsequently been added, as experience has shown that this was feasible.

A few of these benefits which had been added were subsequently withdrawn, due to the fact that inclusion of these additional procedures in the schedule was causing the plan to operate at a deficit, for the first time; and it was recognized that continued payment for these procedures would have made it necessary to increase the premium rate.

Excellent Record

Many factors have been responsible for the fact that our Blue Shield Plan has for several years continued to rank among the best in the nation in the percentage of the premium dollar which is paid back to its subscribers in the form of benefits. The principal reason for this excellent record unquestionably is the devotion and efficiency of the men and women of our staff—from the Executive Director on down to the clerical helpers. The sound policies established by the Board of Directors and the careful management of the finances of the plan must also be given due credit. Without the loyal support of the members of KSMA, such success would have been impossible.

In spite of this excellent record, there are increasing indications that the time has come for a re-evaluation of the schedule of benefits. Comments and criticism from subscribers and from the participating physicians reveal that many of these believe that some of the specific indemnities offered are unrealistically low, while those allowed for some other procedures more nearly approximate the normal or usual charge for the service rendered.

It is hardly necessary to point out that, because our plan is an indemnity one, the physician should suffer no hardship from the above facts, since he is at liberty to charge his patient the difference between what he believes to be a just and reasonable fee and the amount allowed by the plan for the service rendered. On the other hand, it is at times somewhat difficult for the subscriber to understand why in one instance the Blue Shield plan pays a large proportion of his bill and, in other cases, a relatively small proportion.

Extensive Study Ordered

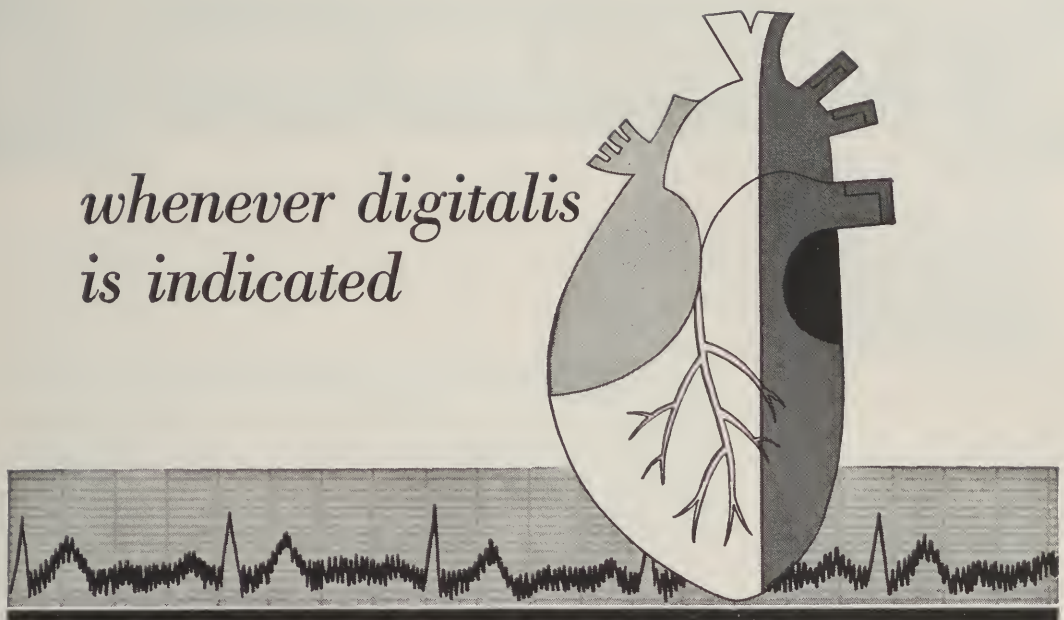
It is for these reasons that the Board of Directors of KPM agreed that a restudy of the entire schedule of benefits is now necessary. The Board has directed its Medical Advisory Committee, under the chairmanship of Richard J. Rust, M.D., Newport, to initiate such a study in the near future. This is to be an extensive and painstaking project, and will require much study to determine the usual value of one procedure as compared to that of another.

The recommendations of this committee will almost certainly lead to considerable revision of the schedule of indemnities, in order to make this schedule more equitable than it now is. Obviously, if the premium rate for the standard contract is not to be increased, it will be necessary to decrease the allowances for some procedures—if those for other procedures are to be increased or if new benefits are to be added.

For those subscribers who can afford to pay higher premium rates and who desire to have a higher proportion of their fees covered by the Blue Shield payments, there is already in operation a "preferred" schedule which can be purchased either through group contracts or on an individual basis. In many instances, the allowances made by this schedule may be sufficient to pay most, if not all, of the usual or normal charge which the physician makes for his services.

W. Vinson Pierce, M.D.

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WASHINGTON NEWS DIGEST



Washington, D. C.—An omnibus bill approved by the House Ways and Means Committee contains two provisions of major importance to physicians—Social Security coverage for doctors and a Federal-state program to provide health care for older persons with low incomes.

About 150,000 self-employed physicians would be covered by Social Security on the same basis as lawyers, dentists and other self-employed professional people now are covered. Becoming effective for taxable years ending December 31, 1960, or June 30, 1961, self-employed physicians would be required to pay a Social Security tax of 4½ per cent of the first $4,800 of income. Physicians also would be subject to the automatic increases in the Social Security tax in future years.

Interns Covered For First Time

Medical and dental interns would be covered for the first time also.

Rep. Wilbur Mills (D., Ark.), chairman of the Ways and Means Committee, was the main architect of the health program for "medically indigent" aged. It was designed to provide a broad range of hospital, medical and nursing services for persons 65 years of age and older who are able financially to take care of their ordinary needs but not large medical expenses.

It would be up to each state to decide whether it participates in the program. The extent of participation—the number of benefits offered to older persons—also would be at the option of individual states.

States Would Determine Eligibility

The states would determine the eligibility of older persons to receive benefits under the program. However, the legislation laid down a general framework for eligibility: persons 65 years and older, whose income and resources—taking into account their other living requirements—are insufficient to meet the cost of their medical care.

The program couldn't become effective until July 1, 1961. Before putting such a program into effect, a state would have to submit to the Federal government a plan meeting the general requirements outlined in the legislation.

The program would be financed jointly by the Federal and state governments. Federal grants would have to be matched by participating states on the same basis as under the present old-age assistance formula.

States could elect to provide, with Federal financial aid, any or all of the following benefits:

(1) Inpatient hospital services up to 120 days per year; (2) skilled nursing-home services; (3) physicians' services; (4) outpatient hospital services; (5) organized home care services; (6) private duty nursing services; (7) therapeutic services; (8) major dental treatment; (9) laboratory and X-ray services up to $200 per year, and (10) prescribed drugs up to $200 per year.

The committee put a $325 million price tag on the program for the first full year of operation—$185 million Federal and $140 million state. However, this estimate could hardly be more than an educated guess of sorts. The actual cost would depend upon unpredictable factors—how many states would participate, how many benefits they would offer, and how many older persons would qualify and what services they would require.

The committee estimate was based on between 500,000 and 1 million older persons a year receiving health services under the program. If all states participated fully, the committee said, potential protection would be provided as many as 10 million aged whose financial resources are so limited that they would qualify in case of serious or extensive illness.

Payments under the program would go directly to physicians and other providers of medical, hospital and nursing services.

Similar to AMA's Point 2

In addition to the Federal grants for the "medically indigent," about $10 million more in Federal funds would be authorized for payment to states for raising the standards of medical care benefits under present public assistance programs for older persons.

The approach of the Mills program was similar to that of Point 2 of the American Medical Association's eight-point program for health care of the aged. Point 2 stated that the AMA supports Federal grants-in-aid to states "for the liberalization of existing old-age assistance programs so that the near-needy could be given health care without having to meet the present rigid requirements for indigency." Such a liberalized definition of eligibility should be determined locally, the AMA said.

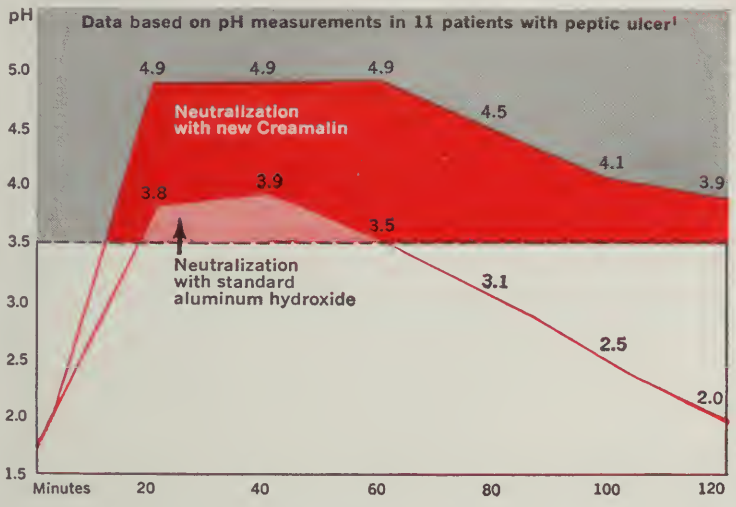
Approval of the Mills plan by the committee marked a sharp setback for organized labor leaders. But they continued their all-out pressure campaign in an effort to get Congressional approval of Forand-type legislation that would use the Social Security system to provide hospitalization and medical care for the aged. After being defeated in the Ways and Means Committee, labor union leaders and other supporters of Forand-type legislation directed their

(Continued on Page 854)

At the site of peptic ulcer



Following determination of basal secretion, intragastric pH was continuously determined by means of frequent readings over a two-hour period.



neutralization is much faster and twice as long with

New CREAMALIN® ANTACID TABLETS

New proof in vivo[1] of the much greater efficacy of new Creamalin tablets over standard aluminum hydroxide has now been obtained. Results of comparative tests on patients with peptic ulcer, measured by an intragastric pH electrode, show that new Creamalin neutralizes acid from 40 to 65 per cent faster than the standard preparation. This neutralization (pH 3.5 or above) is maintained for approximately one hour longer.

New Creamalin provides virtually the same effects as a liquid antacid[2] with the convenience of a tablet.

Nonconstipating and pleasant-tasting, new Creamalin antacid tablets will not produce "acid rebound" or alkalosis.

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles of the powder offer a vastly increased surface area for quicker and more complete acid neutralization.

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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

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Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

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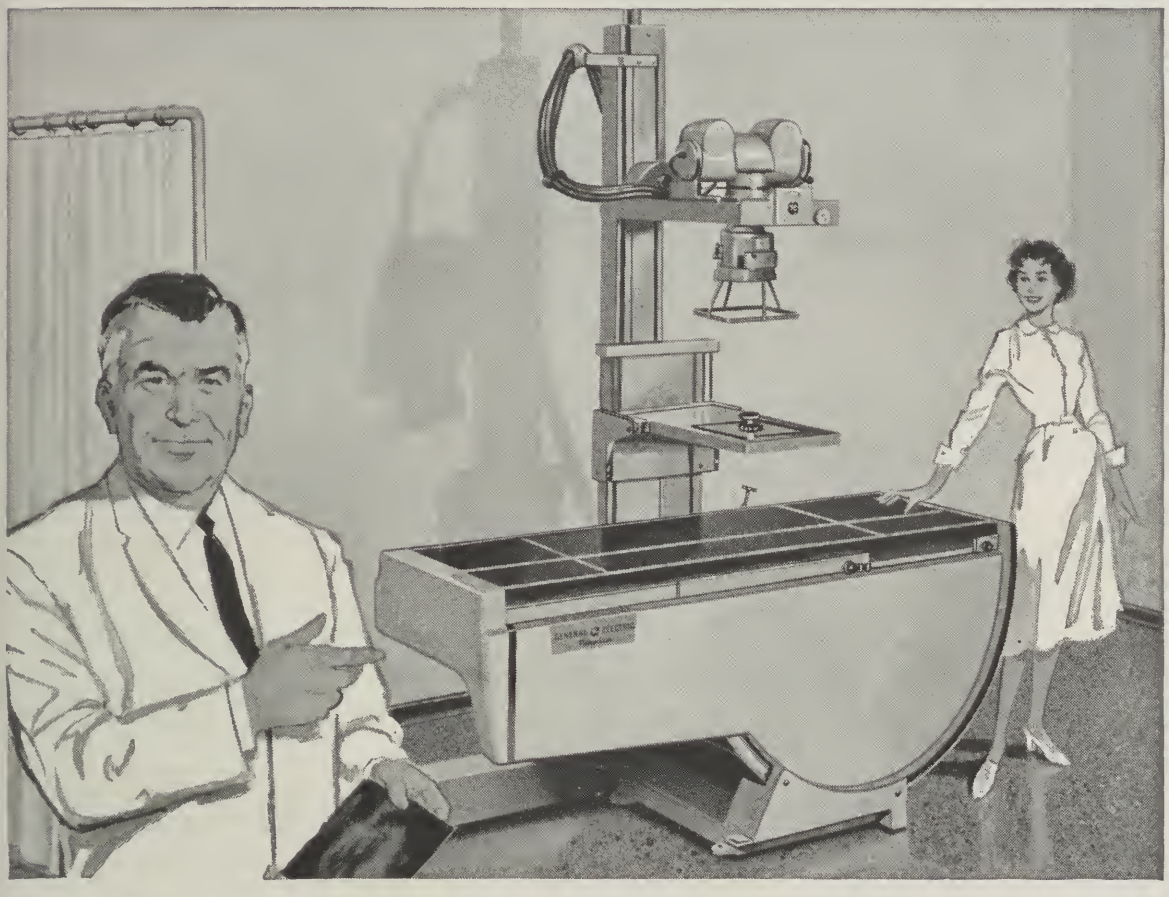
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1. Spoor, H. J.: N. Y. State J. Med., Oct. 15, 1958

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**Berberian, D. A., and Slighter, R. G.: J.A.M.A.* 168:2257 *(Dec. 27) 1958.*

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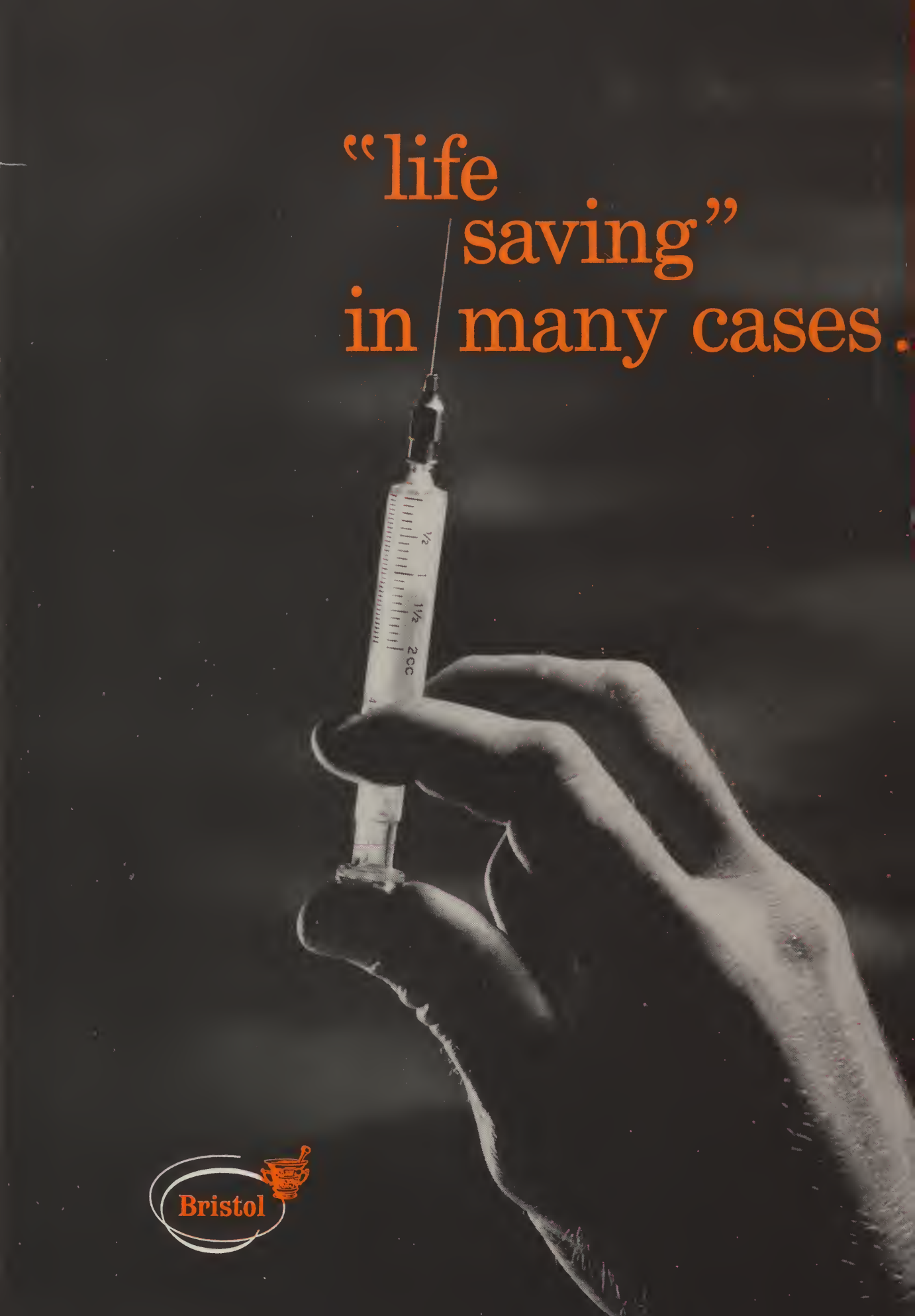
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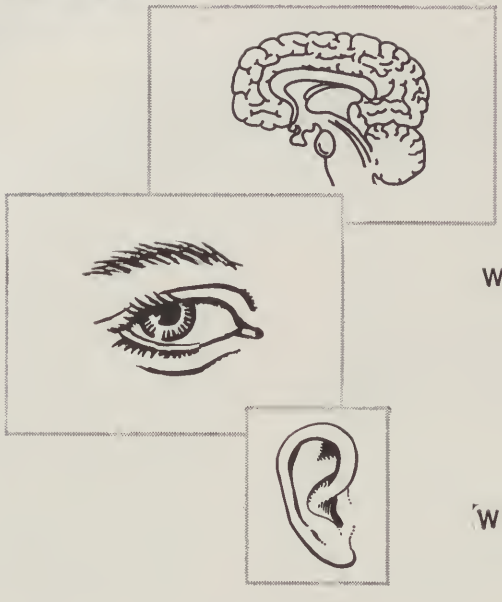
REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

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References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

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Diagnostic Quandaries

Colitis? Gall Bladder Disease?
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Rheumatoid Arthritis? Regional Enteritis?

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Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin.

Write for descriptive literature, bibliography, and dosage schedules.

1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. *6*:1821 (Dec., 1955).

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

3. Webster, B.H.: Amebiasis, a Discase of Multiple Manifestations, Am. Pract. and Dig. of Treat. *9*:897 (June, 1958).

*U.S. Pat. No. 2,864,745

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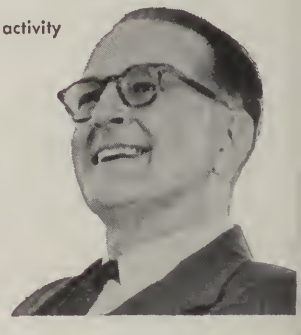
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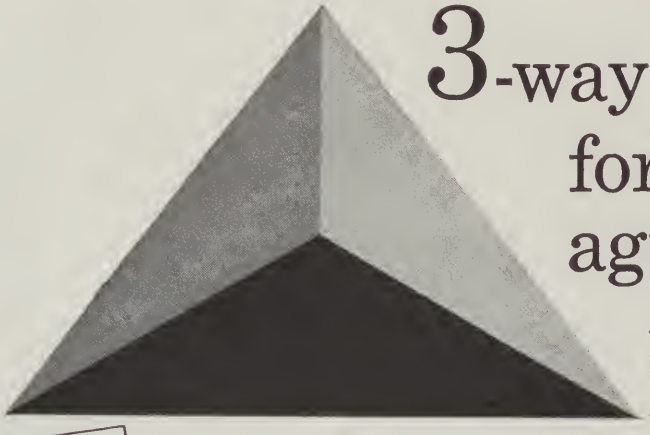
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DOSAGE: Gonorrhea in the male — Six capsules of TETREX in 3 divided doses, in one day.

* Marmell, M., and Prigot, A.: Tetracycline phosphate complex in the treatment of acute gonococcal urethritis in men. Antibiotic Med. & Clin. Ther. 6:108 (Feb.) 1959.

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Please send me . . . free copies of the Wesson cook book "101 Glorious Ways to Cook Chicken."

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The JOURNAL of the
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ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 58 JULY, 1960 NO. 7

Roentgenographic Diagnosis Of Arthritis*

RALPH C. QUILLIN, M.D.†

Lexington, Ky.

Demonstrable X-ray changes as a rule are not one of the early diagnostic features of the disease, with the exception of acute suppurative arthritis

A review of the literature[1] reveals that there are at least 50 disease entities in which arthritis may be a symptom. The degree of joint involvement varies and may or may not be demonstrable on a roentgenogram. This discussion will be limited to the more common arthritides, with particular reference to rheumatoid arthritis, gouty arthritis, osteoarthritis and suppurative arthritis.

Rheumatoid Arthritis

Rheumatoid arthritis is a diagnosis which may refer to rheumatoid arthritis involving the joints of the extremities, rheumatoid (ankylosing) spondylitis, or juvenile rheumatoid arthritis. These disease entities show a definite relationship of pathologic features. To understand the roentgenographic changes that appear in rheumatoid arthritis, one must familiarize himself with the pathology of the disease.[2]

The prominent pathologic change in rheumatoid arthritis is in the synovial membranes. This is a chronic inflammatory reaction. The synovial tissues develop finger-like processes which project into the joint space and expand the joint capsule. The proliferative changes in the synovium may extend over the articular cartilages. The proliferative and inflammatory changes in the synovium produce a gradual absorption of the articular cartilages and deossification of the subchondral cortices. Subluxations then occur and absorption of the ends of the bones may occur. Telescoping of the phalanges of the hands and feet may result. Secondary osteoarthritic changes may follow subsidence of the painful phase of the disease. Secondary osteoarthritic changes also may occur in joints depleted of their cartilaginous cushionings.

Rheumatoid (ankylosing) spondylitis is primarily a disease of young adults. A high familial incidence is reported. The earliest roentgenographic findings are lesions in the upper portions of the sacroiliac joints, giving bones a ground-glass appearance with poor marginal definition. Cancellous bone adjacent to the joints later becomes sclerotic, and irregular osteoporotic or cystic areas are observed in the subcortical zones. The articular margins become irregular and sometimes appear to be widened. Often bony bridges appear to form across the joint space. Sclerosis and bony ankylosis with eventual obliteration develop in most cases. The

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apophyseal joints are similarly, but less consistently, affected. Paravertebral calcification generally is observed only after sacroiliac and apophyseal changes have developed. Osteoporosis occurs, as a late manifestation, in 30 per cent of cases. (Fig. 1)

In juvenile rheumatoid arthritis the large joints (knees and ankles) usually are involved initially, but later any joint in the body, with the exception of the sacroiliacs, may be affected. An outstanding feature of spinal arthritis in children is the lack of calcification in the paravertebral ligaments. Flexion deformities of the neck and a shortened stature frequently result.

As a rule, the sacroiliac joints and spine are not involved in rheumatoid arthritis of the joints of the extremities. The sites of predilection are: the small joints of the hands and feet (especially the proximal interphalangeal joints, metacarpophalangeals and metatarsophalangeals), wrists, ankles, knees, elbows, hips and shoulders. Multiplicity of involvement and bilateralness are the rule. The initial roentgenographic finding in the joints of the extremities is osteoporosis, which may be generalized or juxta-articular. This, however, is a non-specific finding; the earliest manifestations establishing a specific diagnosis are surface articular erosions. These erosions usually occur within six months of onset of the disease, but in some cases may not appear for several years.[2] As the disease progresses, the erosions become irregularly enlarged and are associated with narrowing of the joint space, subluxations and ankylosis. (Fig. 2)



Figure 1
Rheumatoid spondylitis, advanced stage, showing 1) obliteration of the sacroiliac joints; 2) calcification of the intervertebral ligaments (bamboo spine); 3) deossification of vertebral bodies; 4) calcification of nucleus pulposus. Note: Normal hip joints.



Figure 2
Advanced rheumatoid arthritis of hand and wrist. Carpal bones are partially destroyed and fused. The metacarpal heads are destroyed. The metacarpals are subluxated. There is ulnar deviation of the fingers. The wrist joint is destroyed. Note: Distal interphalangeal joints of the fingers are normal.

Gouty Arthritis

Of the estimated twelve million arthritics in the United States, 4 per cent (480,000) are reported to have gout[1]. Males predominate, 20 to 1. Gouty arthritis is a manifestation of the systemic disease. The systemic manifestations of gout may appear early in life. During the early phase of the disease, many joints may be involved. It is during this phase of the disease that error in diagnosis is most common. Gout often is diagnosed as rheumatic fever or as acute or chronic rheumatoid arthritis. There has been a fixed medical opinion that gout is an old man's disease. To the contrary, it not infrequently occurs in individuals in early life.

The essential pathology in gout is attributable to deposition of uric acid, especially about the

smaller vessels beneath the subchondral cortices and near the joints. Accumulation of urates also occurs in the kidneys.

From a roentgenographic standpoint, the joints most frequently involved are the small joints of the feet (particularly the first metatarsophalangeal joint), the small joints of the hands, the wrists, and occasionally the elbows and knees. During the early stage of the disease, almost any joint may be involved. The roentgenographic manifestations appear in the para-articular soft tissue and articular cartilages. Para-articular swelling and edema is common. Areas of soft tissue nodulation and periosteal tuftings, especially around the proximal phalanges, also occur. Erosions and subcortical cystic defects may be noted, as well as expansions of the joint capsule. Eventual reduction in the interosseous spacing and subluxations may be observed. At times calcified opacities are noted in subcutaneous masses.

Osteoarthritis

Osteoarthritis is also commonly referred to as degenerative joint disease. It is largely a clinical diagnosis. X-ray findings are not always an adequate basis for the diagnosis and do not always indicate the degree of joint incapacity. The term "osteoarthritis" as ordinarily employed refers to a joint disturbance wherein the essential pathology is that of fibrillation and compression of the articular cartilages. There is loss of normal cushioning. Ordinary joint function becomes irritating and, reflexly, there develops a hyperemia in the adjacent bone ends. Probably due to the latter reaction, some deossification takes place in the osseous structures, but there is advancement of calcification and ossification into the cartilaginous strata, with production of eburnation and marginal spurs.

Contrary to widespread teaching, this type of joint pathology is not a disturbance restricted to the older age groups. Marked osteoarthritic changes may at times be seen in patients in their second or third decade. Osteoarthritis may be superimposed on almost any basic type of joint pathology. When it occurs in the younger age group, there is a challenge to identify the basic etiologic factor.

Osteoarthritis of the hip is the most painful and disabling form of osteoarthritis. In the hip and other weight-bearing joints, subchondral sclerosis indicates severe cartilaginous damage, rather than avascular necrosis. Flattening of the head of the femur indicates that bony debris has entered the joint. Cystic defects beneath the osseous articular cortices are found only when degenerative changes are advanced and continued use of the joint has impeded the natural processes.

Sites of predilection are the large weight-bearing joints. When trauma is definitely a factor, one or a few joints are involved. Otherwise, multiplicity of involvement and bilateralism are the rule. All segments of the spine may be involved.

Symptomatic Arthritis

Lupus erythematosus. In disseminated lupus erythematosus,[3] the arthritic change is manifested by deformities and osteoporosis without erosion or joint narrowing. Lupus erythematosus may, however, develop in patients with rheumatoid arthritis, complicating the differential signs. The pathological changes[1] noted with Lupus erythematosus, and also common in rheumatoid arthritis, periarteritis nodosa, dermatomyositis, scleroderma and rheumatic fever, include edema in the connective tissue, fibrinoid cellular infiltration, and vascular and fibroblastic proliferation. Articular manifestations occur in a large per cent of patients with Lupus erythematosus.[1] The joint manifestations may vary from a mild, transient joint pain (arthralgia) to a situation simulating deforming arthritis. Thirty per cent of patients develop permanent clinically or roentgenologically visible evidence of arthritis.[4]

Periarteritis nodosa. Synovitis rarely occurs in periarteritis nodosa; but when it is present it may simulate rheumatoid arthritis.

Scleroderma. Scleroderma[3] produces a generalized atrophy of the soft tissues, and the joints become fixed and deformed by these changes. Osteoporosis of the involved bones, resorption of the terminal phalanges of the hand, and soft tissue calcification are diagnostic criteria.

Psoriatic arthritis. An association between psoriasis and rheumatoid arthritis is considered by many to be well established. Three criteria are usually suggested as necessary to the di-

agnosis of "psoriatic arthritis":[4] 1. Exacerbations and remissions of the two diseases coincide (although the original appearance of either may precede the other by many years). 2. The distal interphalangeal joints are involved. 3. Resorption of bone occurs at the articular margins. Psoriasis involving the nails is not necessarily associated with arthritis of the corresponding terminal phalangeal joints. In psoriatic arthritis the x-ray findings are those of destruction of the joint surface and increased bone density, producing the so-called "pencil-in-cup" deformity.

Suppurative arthritis. Because of the steady decline in infectious disease with steady improvement in therapeutic measures for the control of infections, suppurative arthritis may some day become a clinical curiosity. Acute suppurative arthritis in premature infants and children under one year of age presents a serious problem. Systemic reactions are so deceptively mild in patients that early diagnosis is often not made and irreparable damage to joints may occur. The average age of onset of this disease is 12 days. It is usually confined to a single joint, most often the hip and at times the shoulder. Roentgenograms taken early in the course of the disesae may not reveal widening of the joint space or dislocation but may, within a few days, show a soft tissue shadow in the region of the joint. In adults, suppurative arthritis usually involves a single joint, with no tendency toward bilateralism. Inflammation and distention of the joint capsule occurs within one day. Within 7 to 14 days erosions of the articular cortices and the adjacent portions of the bone occur. Fibrous ankylosis may result within a month; osseous ankylosis, within 6 to 10 months. The sites of predilection include the knee, hip, wrist or ankle.

The following case report illustrates this disease:

> J. G., a 26-month-old white male, was hospitalized on Oct. 8, 1959, because of pain and swelling in the right shoulder area. There was no history of known injury. Mother stated that the child had complained of some pain in the shoulder for at least a week; however, swelling was first noticed on the evening prior to admission. Positive physical findings were limited to the right shoulder which showed rather marked swelling and any attempt at motion produced rather severe pain. X-rays at that time showed widening of the joint space, but no evidence of bone destruction (Fig. 3A)
>
> Laboratory studies on admission were: RBC 5.4m., Hgb. 13.7 gm., WBC 18,176 with 67% neutrophils, 28% lymphocytes and 4% monocytes. The urine was negative. Blood cultures showed no growth after eight days.
>
> The temperature was only 100°F. on admission and returned to normal on the second day. He was started on 600,000 units of penicillin and 200 mgm. of Ilosone® every six hours. After six doses, the Ilosone was reduced to 125 mgm. every six hours. Improvement was rapid. He was discharged

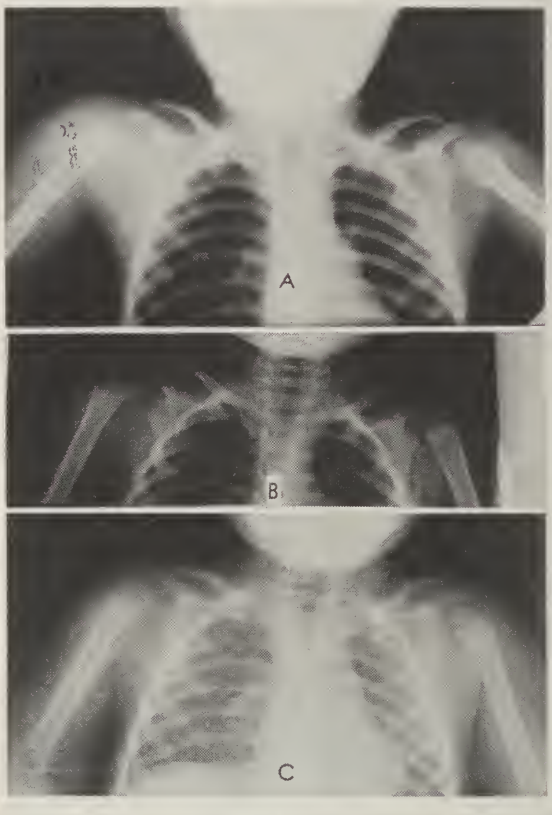


Figure 3

3A. Marked soft tissue swelling around right shoulder joint with some widening of the space but no evidence of bone destruction.

3B. Six days later. Swelling reduced considerably. Beginning periosteal calcifications around upper humeral shaft.

3C. 14 days later. Shoulder joint normal. Marked periosteal reaction.

on Oct. 11, 1959, with no evidence of pain or swelling. Penicillin was discontinued. He remained on Ilosone 125 mgm. q 6 hr.

An x-ray made on Oct. 14, 1959, showed a moderate amount of periosteal reaction around the upper right humeral shaft and minimal bony irregularity of the metaphysis. (Fig. 3B) The clinical and x-ray impression was healing hematogenous osteomyelitis. Ilosone medication was continued.

X-rays made Oct. 28, 1959 showed marked periosteal new bone formation and a normal shoulder joint. (Fig. 3C) Medication was discontinued.

He was seen on Nov. 4, 1959 and was completely free of symptoms. There was palpable thickening of the right humerus.

Summary

The pertinent roentgenographic features of rheumatoid arthritis, gouty arthritis, osteoarthritis and suppurative arthritis along with other associated findings are reviewed.

Symptomatic arthritis occurring in Lupus erythematosus, Scleroderma and Psoriatic arthritis is discussed.

A case of suppurative arthritis occurring in a child is presented.

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AN OUTSTANDING PROGRAM

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1960 KSMA ANNUAL MEETING

September 20-22, 1960

Columbia Auditorium, Louisville

The Laboratory Diagnosis Of Infectious Diseases Of the Lung*

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Lexington, Ky.

Close cooperation of the physician, patient and microbiologist is required. Viruses, bacteria or fungi must be considered as potential etiologic agents

THE laboratory diagnosis of pulmonary infections may be accomplished by:

1. Isolation and identification of the etiologic agent
2. Serologic tests to aid or confirm the clinical diagnosis
3. Skin tests to demonstrate microbial hypersensitivity as an index of past or present infection

Our experience has indicated that, with judicious application and interpretation of the laboratory findings, almost all pulmonary infections of bacterial or fungal etiology and, to a lesser extent, viral infections can be diagnosed by using one or a combination of the above-mentioned approaches. Isolating and identifying the causative agent affords the most exact diagnosis, but this is not always possible. Some organisms cannot as yet be cultured or are cultured only with great difficulty. There are instances when the suspected lesion is not accessible and there are some diseases which yield organisms only at certain stages of the disease. Therefore, the clinician will often find consultation with the microbiologist useful in the diagnosis and therapy of infectious diseases.

Viral Infections

Diagnostically, viral infections of the lung do not present a serious problem. This does not imply that there are no serious viral respiratory diseases. One need look no further than influenza to be aware of a serious and far-reaching infectious viral disease; however, influenza is primarily a disease of the upper respiratory tract and by the time it reaches the lungs the infection has been augmented by secondary bacterial invaders.

In addition, influenza is usually diagnosed by clinical symptoms. Diagnosis is supported by the laboratory if mouth washings, collected in the early stages of the disease, are inoculated into chick embryos to isolate and identify the virus. It is also possible to diagnose influenza by obtaining paired serum specimens taken at the onset of the infection and again two to three weeks later. The two serologic procedures most frequently used are the complement fixation test, using representative strains of the different serologic types of influenza virus as antigen, and the hemoagglutination inhibition test. A rise in titer against one of the antigens is indicative of infection with that specific type of virus.

Two viruses produce primary infections in the lung in the form of a pneumonia. One is the pneumonia caused by one or more of the adenoviruses, a relatively new group of viruses that commonly produce pharyngitis, conjunctivitis, and acute respiratory disease. Occasionally an

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illness resembling primary atypical pneumonia is the chief finding. The illness shows the clinical features of primary atypical pneumonia: pneumonitis, either unilateral or bilateral, which tends to be most prominent in the bases with increased peribronchial densities extending to the diaphragm. There is, however, no development of cold agglutinins or Streptococcus MG agglutinins, as is the case with most primary atypical pneumonia infections.

The laboratory diagnosis of adenovirus infection is preferably made by isolating the virus in tissue culture and then typing the virus. The complement fixation test or the tissue neutralization test is also used; however, these procedures are available only in a few regional laboratories at present.

Primary Atypical Pneumonia

The other viral pneumonia that occurs with moderate frequency is primary atypical pneumonia. Here, too, the diagnosis is initially made by the clinical findings. Cold hemagglutinations and agglutination of Streptococcus MG have been used extensively as retrospective aids in the laboratory diagnosis of primary atypical pneumonia. Both tests are commonly performed on paired serum specimens, one taken during the acute phase and the second, two to three weeks later, during the convalescent phase. A positive titer with a fourfold increase in the second serum specimen of either or both agglutination tests provides the physician with reasonable assurance that his diagnosis was correct.

It is advisable to have both the cold agglutination and the Streptococcus MG agglutination test done rather than either alone, because each test will be positive in about 50 per cent of the cases of primary atypical pneumonia.

Bacterial Infections

Bacteria are by far the most commonly encountered infectious agents in pulmonary infections. There are twelve or more different genera, let alone species, of bacteria that may be responsible for lung disease. The laboratory diagnosis obviously requires a competent bacteriology staff and the close cooperation of the physician, patient and microbiologist. The patient should be instructed by his physician to provide the laboratory with a fresh sputum specimen. The physician also should supply the laboratory with specific instructions concerning the cultures he desires, or with sufficient information so that the microbiologist may use his judgment as to how the sputum should be cultured.

A preliminary examination of the sputum specimen itself is often quite helpful. In typical cases of pneumonococcal pneumonia, the sputum is "rusty" or contains many flecks of blood. Gram stains will show almost nothing but gram-positive diplococci. These can easily be cultured and identified with overnight incubation. Friedlander's pneumonia, whether acute or chronic, usually presents a thick, tenacious sputum and a preponderance of short, plump, gram-negative bacilli. Here, again, positive cultures and identification are established through study of morphology and biochemical reactions.

A sputum specimen that is purulent in appearance is suggestive of a pyogenic infection with streptococci or staphylococci or of tuberculosis or fungus infection. Beta hemolytic streptococci are occasionally responsible for bronchitis or interstitial bronchopneumonia resulting from a downward extension of an upper respiratory tract infection.

Pleurisy a Common Complication

Because of the retrograde extension of a streptococcal infection, pleurisy is a very common complication, with the formation of considerable serofibrinous pleural exudate. When this complication occurs, the diagnosis is simplified, as the organisms can be isolated from the pleural fluid in pure culture and the presence of alpha or beta hemolytic streptococci is verified.

The incidence of staphylococcal pneumonias is definitely increasing. Tracheobronchial staphylococcal infections are severe, fulminant and frequently fatal. Pulmonary abscesses and generalized septicemia develop rapidly unless the organism is promptly cultured and identified, and proper antibiotic therapy instituted. Staphylococcal pneumonia has also been observed as a complication of staphylococcal enteritis[10] and this, too, has a grave prognosis. It is of extreme importance in these instances that antibiotic sensitivity tests be done in order

to establish the susceptibility pattern and permit the selection of the most appropriate drug. Delay in starting antibiotic therapy and the selection of non-effective antibiotics have resulted in a fatal outcome in many instances.

Tuberculous Pneumonia

In almost every instance of pulmonary infection, tuberculosis must be given prime consideration. Acute tuberculous pneumonia is extremely difficult to diagnose by clinical criteria, as it may have the same characteristics as other pneumonias. It is, therefore, essential to obtain bacteriologic studies to establish the diagnosis. Subacute and chronic pulmonary tuberculosis frequently present X-ray and clinical findings that may be strongly indicative of tuberculosis, but, again, the diagnostic proof can come only with the demonstration of tubercle bacilli by culture and, if necessary, by animal studies.

Serious diagnostic errors are made by concluding that acid-fast bacilli on sputum smears are tubercle bacilli.[11] Reliance on smears alone should be discouraged, because it is not possible to distinguish between tubercle bacilli and saprophytic mycobacteria or acid-fast Nocardia. The same error in diagnosis is often made by relying solely on a positive skin-test reaction to old tuberculin or to purified protein derivative. The tuberculin skin test is useful in diagnosis, especially among children, but, like all skin tests, it has its limitations. A positive reaction implies a hypersensitivity to a protein fraction of the tubercle bacillus, but it cannot distinguish between past and present infection.

Systemic Infections

Several systemic infections occasionally give rise to pneumonia. Foremost among these is salmonellosis, with S. syphosa and S. cholerasuis,[1] most frequently isolated; pasteurellosis, with P. tularensis and P. multocida predominant; and brucellosis.

Several of the points just covered are illustrated by the case of an 18-year-old white male who was being examined as part of a pre-employment physical. A lesion in the left lower lung was found, and the patient gave a history of a chronic productive cough of several years duration. Following a thorough examination in which tuberculosis and fungus infection were ruled out, a diagnosis of bronchiectasis was made. A segmental resection of the left lower lobe was done and the postoperative course was uneventful for the first four days. At that time the patient's temperature became elevated and chest X-rays showed fluid in the left pleural space up to the hilum and 40% pneumothorax. Three hundred fifty ml. of purulent fluid was aspirated from the anterior and posterior chest. Cultures of this fluid gave a mixed growth of alpha hemolytic streptococci and Pasteurella multocida. The patient was treated with oral penicillin and streptomycin. The postoperative course was one of gradual improvement; when last seen, the patient had completely recovered.

Isolation of Organisms

All these different organisms can be isolated and identified by the microbiologist if he is constantly on the alert for the less frequent infections or if the attending physician indicates that the patient's history or the clinical findings suggest something out of the ordinary. Occasionally, the laboratory provides the initial impetus for more thorough culture work from the result of serologic tests for brucellosis, tularemia or salmonellosis. If a suggestive inital titer is promptly followed by attempts to isolate the indicated organism, the diagnosis is frequently confirmed. There are, of course, instances when all attempts at isolation of the responsible organisms fail. In these instances the diagnosis is established rather convincingly if a distinct rise in titer occurs on repeated serologic testing.

Mixed bacterial populations are found in patients with emphysema, bronchiectasis, chronic tuberculosis and chronic fungus infections. In these instances, it is necessary to examine properly stained slides or wet mounts and to culture the material to yield growth of the diverse organisms present. The interpretation of the cultural results necessitates a clear knowledge of the organisms indigenous to man and their distribution within or on the normal human body.

Fungal Infections

Systemic fungus infections have shown a decided increase in incidence and severity over

the past fifteen years. This has been attributed in part to the introduction of the broad-spectrum antibiotics, which bring about a disturbance in the normal flora and permit the growth of fungi previously held in check. The use of corticosteroids has also been responsible for the dissemination of fungal infections which otherwise would remain localized.

The demonstration and isolation of fungi in sputum or bronchial excretions is not easy. It is necessary to suppress the bacterial flora to facilitate the growth and isolation of the offending fungus. In addition to improving and perfecting cultural techniques, the development of serologic techniques and skin-testing preparations has greatly facilitated the diagnosis of fungus infection of the lungs.

Kentucky is located in the center of the areas where histoplasmosis and blastomycosis are endemic. These two diseases comprise the greatest percentage of pulmonary fungus infections that we have seen.

Histoplasmosis

Histoplasmosis is no longer considered to be a rare disease. It is rather widespread and is capable of causing a wide variety of clincial pictures.[7,8] Pulmonary histoplasmosis is the most common form, and should be given consideration in the differential diagnosis of acute and chronic lung infections.[15] The clinical courses of the disease ranges from an unapparent infection to a disseminating, fulminating, fatal infection. Laboratory diagnosis often requires the use of every available technique.[3] In the early stages of the disease, it is frequently impossible to isolate the diphasic fungus from sputum or bronchial washings.

The cultural technique of choice involves the injection of mice with antibiotic treated sputum or bronchial washings. If cavitation and calcification, which are quite common, develop and the patient is operated on, the organisms are frequently found in the histoplasmoma by the pathologist. If not placed in fixative, the tissue will frequently yield Histoplasma capsulatum when cultured on the standard fungus media or injected into mice. In the majority of cases it is necessary to rely on indirect means of diagnosis of histoplasmosis.

A positive reaction to the skin test for hypersensitivity to histoplasmin, along with a simultaneously negative tuberculin and blastomycin reaction, is considered to be strong supportive evidence to existing X-ray and clinical findings. Additional evidence can be obtained from the agar-gel diffusion precipitation test and the collodion-particle agglutination test. We have also obtained good results from the complement fixation and precipitation tests, especially when the intradermal test is negative. Serologic tests also can be used to determine whether a positive skin test is due to active or past infection.

Blastomycosis

Gilchrist first described North American blastomycosis as a dermatitis caused by a protozoan parasite.[4] We have since learned that blastomycosis is primarily a pulmonary infection and is caused by a diphasic fungus. The pulmonary lesion may resemble histoplasmosis, tuberculosis or pneumonia.[12] From this primary focus the infection disseminates to involve the skin, bones and, occasionally, other organs. Therefore, blastomycosis has to be considered in the differential diagnosis of chronic pulmonary infections, especially in this locale.[9] It is also advisable to consider blastomycosis in any persistent granulomatous skin or bone lesion, as these may be the first clinical manifestation of the infection.

Early diagnosis is of decided advantage, as this is one of the systemic mycoses most responsive to therapy, and prompt institution of treatment can prevent systemic spread. Diagnosis is most frequently made by direct examination and culture of the sputum or bronchial aspirations. Tissue biopsy is also useful. The intradermal skin test is a useful auxiliary diagnostic tool, using either a mycelial extract, blastomycin or a yeast-phase vaccine. Specificity of a positive skin test should always be checked by testing for tuberculosis and histoplasmosis at the same time. The complement fixation test is also helpful in determining active disease. Unfortunately, intradermal and serologic tests are frequently negative in proved blastomycosis.

A typical case of pulmonary blastomycosis from our files is that of a 57-year-old white female, first seen in July, 1957. In February of

the same year she had the "flu" and had not felt well since. She complained of low-grade fever toward the end of each day, slightly productive cough on arising in the morning, and occasional slight thoracic pain. Chest X-rays revealed a moderate amount of infiltration with a 3 cm. cavity in the upper lobe of the left lung and a small area of infiltration in the right lung at the first interspace. This was interpreted as being typical of tuberculosis.

Five sputum specimens submitted to the microbiology laboratory failed to show any acid-fast bacilli, and cultures were all negative for tubercle bacilli. However, the acid-fast smears of the last sputum specimen showed what appeared to be distorted, thick-walled, yeastlike cells. The distortion was due to the heat employed in the staining procedure. A fresh sputum specimen showed typical budding cells of Blastomyces dermatitidis. Fungus cultures confirmed the identification. The skin test for blastomycosis was positive but the complement fixation test was negative. The patient was placed on 2-hydroxystilbamidine and made a slow but steady recovery. She refused to take amphotericin-B, as it was still considered an experimental drug at that time. She has been closely followed, and when seen in August, 1959, had a normal chest X-ray and no other sign of active infection.

Cryptococcosis

Cryptococcosis is another fungus disease that is increasingly recognized as a cause of pulmonary lesions. In fact, the respiratory tract is considered by many to be the portal of entry.[2,5] Laboratory diagnosis is made by culturing, on ordinary laboratory media, sputum or material obtained by bronchoscopy or surgery. In disseminated cryptococcosis, the spinal fluid is frequently positive for the budding yeastlike cells characteristic of Cryptococcus. A growth of heavily encapsulated, budding, yeast-like cells is in all likelihood Cryptococcus, and virulence studies by mouse inoculation will establish its pathogenicity and identity as C. neoformans. A skin testing preparation is available, but its efficacy has not yet been established.

Our most puzzling case of cryptococcosis was that of a 15-year-old white male. He had a six-week history of fever, cough and malaise. Chest X-rays revealed two moderate-sized cavities in the left lower lobe. Preoperative studies failed to give a positive diagnosis, and a left lower lobectomy was done. The diagnosis was not made with any degree of certainty until a portion of one of the pulmonary lesions was cultured and inoculated intracerebrally into white mice. Autopsy studies of the mice, with biochemical and capsular swelling tests of the culture, enabled us to identify the organism as C. neoformans and establish the diagnosis as pulmonary cryptococcosis. The patient made an uncomplicated recovery and when last seen had returned to a full schedule of teen-age activities.

Other Fungi

Coccidioidomycosis is a fungus infection rather sharply limited to the Southwest. Skin-test surveys have indicated that two-thirds of the population in the endemic areas are infected. Add to this the vast shift in population that has taken place in the past decade and we have ample reason for suspecting coccidioidomycosis in anyone who has lived in or visited an endemic area and who has an acute or chronic pneumonitis.[14]

Sputum or surgically-removed tissue should be cultured on routine fungus media. The cultures must be handled with extreme caution, as a positive culture is grossly characterized by a powdery filamentous growth that is highly infectious. A presumptive diagnosis is frequently made by skin testing with coccidioidin and complement fixation or precipitation test. Some authorities have indicated that positive intradermal and serologic tests are to be regarded as sufficient evidence for a diagnosis.[13]

Actinomycosis and nocardiosis are two infections produced by branching filamentous fungi. Actinomyces israeli, an anaerobe, is found as a normal inhabitant of the mouth and pharynx. It is capable of producing a chronic pulmonary infection, frequently in the lower lobes, and has a marked tendency to invade the pleura, ribs and subcutaneous tissues. A fistula is often the inital overt symptom of the infection. Microscopic examination of the exudate or tissue will more than likely reveal actinomycotic "sulfur granules."

Cultures of the exudate or sputum must be

incubated anaerobically to insure the growth of A. israeli. A positive sputum culture does not necessarily exclude the possibility of tuberculosis or some other infectious agent, as A. israeli has been isolated from the mucous membrane of the mouths of healthy people and may therefore be a secondary invader.

Further evidence of the need for competent bacteriologic collaboration is demonstrated in the case of a 44-year-old white male, referred to the clinic because a tender, swollen mass had rather suddenly developed in the left posterior lateral lower chest. It was difficult to determine whether this mass was part of a subphrenic abscess or a lateral extension of a pulmonary infection. Chest X-rays revealed an active inflammatory process in the right upper lobe, suggestive of tuberculosis. The patient was hospitalized for surgical investigation. Over 200 ml. of purulent exudate was drained from what appeared to be a subphrenic abscess.

Patient Hospitalized Again

The hospital laboratory was unable to obtain any growth from this exudate, and the pathologist reported no evidence of malignancy. There was no evidence of organic pathology in the gastrointestinal tract. The patient was sent home on sulfonamid therapy, with a drainage tube in the operative site. Drainage did not completely stop nor did the fistula tract heal after eight months. In fact, a second tender mass had developed and it was necessary to hospitalize the patient again. At this time he was admitted to a hospital in which we are laboratory consultants, and when the abscess was again incised and drained, we were able to demonstrate typical "sulfur granules" in the exudate. Anaerobic culture subsequently yielded A. israeli.

The patient was placed on erythromycin, which had previously been used with good results,[6] but after six weeks there was very little improvement. Quantitative antibiotic sensitivity tests showed that the isolated strain of A. israeli was markedly resistant to erythromycin and very susceptible to penicillin. Accordingly, the patient was once more hospitalized for intensive intravenous penicillin therapy. In four weeks he was given a total of 390,000,000 units of penicillin. The sinuses closed completely and the patient's convalescence was uncomplicated. He has returned to work and has had no further complaints.

Nocardia asteroides is most frequently responsible for nocardiosis. It is found as an aerobic saprophyte in the tracheobronchial tree and in the soil. This fungus produces pulmonary disease similar to that of actinomycosis; the two infections can be differentiated only by isolation and identification of the responsible organisms. N. asteroides will give a positive acid-fast stain, and is frequently mistaken for tubercle bacilli when isolated on TB media. Here, again, it is often difficult to assess the true significance of Nocardia when it is isolated from the sputum only. Extreme caution should be taken to distinguish it from Mycobacterium tuberculosis. As yet there are no indirect means available to aid in the diagnosis of either actinomycosis or nocardiosis.

Summary

A well-staffed and equipped laboratory is able to offer several approaches to aid in the diagnosis of pulmonary infections. The various procedures are discussed and several "problem" cases are presented.

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Alcoholism, A Public Health Menace*

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The rehabilitation of alcoholics and their families is a complicated task requiring a coordinated approach at the local, community level

IT IS evident to me that alcoholism is a problem of major proportions to society and that this fact is recognized by many people who have made the effort to inform themselves about alcoholism. It is also evident to me that alcoholism is a public problem *and* a health problem. It is a public problem because the alcoholic so frequently interferes with the health, safety and happiness of others; it is a health problem because the alcoholic frequently needs medical and other kinds of intervention to restore him to health.

Definition

My conception of an alcoholic is that of a person who has a certain way of living that includes or has included the use of alcohol as a necessary feature, that is, a person whose use of alcohol is not self-controlled. It is significant to me that people whose lives have been dominated by alcohol continue to think of themselves as alcoholic, even after they stop drinking. This is an acknowledgment that they are different in some ways than are non-alcoholics. One way in which alcoholics agree they differ is that they cannot tolerate alcohol. A single drink of an alcoholic beverage so undermines self-control that the alcoholic is unable to stop drinking.

A person is not usually recognized as an alcoholic until his behavior, associated with drinking, is disruptive or damaging to his own way of living or to that of others. There is no test that a physician can use, other than his own judgment, to determine whether the patient before him is or is not an alcoholic. The determination, who is an alcoholic, must, therefore, be made on the basis of human assertions, that of the person who says he is unable to control his drinking or on the basis of assertions made by others.

Determining the Truth

This is an important point to keep in mind because the physician who must make an independent judgment is faced with the problem of determining the truth of the assertions. He must be alert to pick up distortions of the truth from his patient and from others and to look for confirmation of his impressions in his examination of the patient. It seldom happens that the patient asserts that he is an alcoholic when he is not, though the reverse, the denial of alcoholism, is very frequent. In fact, in the early stages of alcoholism, the patient insists that he is able to control his drinking long after it is evident that he has lost control.

Statements made by others about the patient, particularly the relatives, may be distorted, exaggerating or minimizing the situation. Evaluating such assertions, as we all know, is no easy matter when they are apt to be based on misperceptions and misconceptions. Less frequently, there is a deliberate, conscious falsification of fact, but it happens often enough for the physician to keep it in mind.

**Address delivered at Kentucky Commission on Alcoholism Seminar held November 5, 1959, Louisville, Kentucky.*

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Public Health Aspects

While every alcoholic is *logically* a public health problem in the meaning of the terms public and health, society does not recognize a disease state as a public health problem until its repercussions on the lives of others require intervention in the private affairs of an ill person by an organized community effort. The sickness of an individual is a private affair between the patient and his physician and, as a practical matter, is not regarded by most people as within the public domain unless his sickness affects the health, safety or happiness of others to such an extent that something must be done to remedy the situation.

There are doubtless many alcoholics who do not come to public attention because they are quietly treated at home by their physicians and who have financial resources of their own so that they and their families do not become public charges. It is not these alcoholics who create a demand for a public health program to combat alcoholism. Rather, it is the large number of alcoholics who cause expense to the community, whose disordered behavior brings them into conflict with law enforcement agencies and whose emotionally disturbed children present such an array of behavioral and learning problems in the schools.

Social Effects

A few illustrations will suffice to explain why it is that society, awakening to the problem of alcoholism, is demanding organized community effort. One of the most important social effects of alcoholism is the disruption of family life. The alcoholic, using alcohol as an integral part of his way of living, is soon rendered incapable by the alcohol of facing life realistically. He is, therefore, severely handicapped in performing his role in the family as a husband and as a father.

As a bread-winner for the family he becomes so ineffective that the family may have to turn to others for economic assistance to survive. The family then appears before community welfare agencies for assistance which must be paid for by the community. As the resources of the family diminish, the alcoholic is unable to afford medical care so that he appears in community health facilities, again as an expense to the community. His disorderly behavior outside of his residence brings him to the attention of the police, the courts and the jails, again at public expense. In short, the alcoholic is brought to the attention of the community largely by the bills the community has to pay for his mismanagement of his personal affairs.

Lately, another concern of the community has developed as a result of the awakening of consciousness in people about the effect the alcoholic has on the developing personalities of his children. This is an area that needs further research but it is already clear that children need healthy parents to become healthy adults. In families where the parents are anxiety-ridden, quarrelsome and irrational, the children are inevitably involved in the cross-fire. It is often impossible in such circumstances for them to develop patterns of human behavior of their own that will permit them to carry on later as mature human beings. The self of the child grows slowly as the result of numerous and intense interactions with his parents and others, which interactions must be reasonably consistent and in conformance with reality for the child to learn to see himself and others realistically.

Plight of Children

This explanation is, perhaps, sufficient to indicate that alcoholism is, among others, a serious factor in the mental health of children. The plight of children in such homes is becoming of concern to the community as people begin to see the implications for the future of these children and the responsibilities the community may have to foot the bill for medical and social services for the children in addition to those provided for their alcoholic parents.

I see the public health approach as essentially an organized community effort to control a health problem; that is, to eliminate it, if possible, and if the elimination of the problem is not possible, to minimize its effect on the community. Elimination of alcoholism as a health problem appears to me to be impossible because, as yet, we do not know the cause.

There are, in general, two kinds of theories about the etiology of alcoholism. One holds that there may be some biological defect in the individual, perhaps metabolic, that makes the person easily addicted to alcohol. The other is

that there is a characterological or personality defect, inherited or developed during the psychological growth of the person, which makes him vulnerable. Neither theory is proved and, even if defects are clearly shown, it would remain to be proved that they are causal rather than occurring as a result of alcohol imbibition. Lacking a known cause of alcoholism, it is clearly impossible to eliminate the cause. Preventive efforts, therefore, cannot be directed against specific etiological factors.

A community approach to combat alcoholism must, therefore, be directed to minimizing its effects on the community. The objective of such a program, as I see it, would be the rehabilitation of the alcoholic and his family. I include the family in the objective because alcoholism is not merely an illness of the alcoholic patient. Other members of the family are involved psychologically in the illness to such an extent that treatment of the alcoholic patient alone is often not sufficient. Very often the spouse of the alcoholic patient requires psychiatric treatment and the children may have developed such distorted personalities that they, too, will require specialized attention.

Community Services Required

The kinds of community services that will be required for the rehabilitation of alcoholic patients and their families may be briefly listed as follows:

1. Medical treatment
   a. Private physicians
   b. Hospitalization
2. Clinic services
   a. Alcoholism clinics
   b. Mental health clinics
3. Social Welfare Services
   a. Child welfare
   b. Public assistance
4. Psychiatric consultation for the patient and and for personnel who work with the patient
5. Vocational rehabilitation services
6. Religious counseling
7. Alcoholics Anonymous and Alanon
8. Community education
9. Public Health nursing services
10. Sheltered workshop for repeat lawbreakers
11. Public Health administration

It is my belief that a community alcoholism-control program should be worked out within the community itself and tailored to fit the community's needs and resources. A local committee or council should be formed made up of citizens awakened to the nature of the alcoholism problem. The initiative for organization of the committee may come from one of the local leaders, an official of government or a state or national voluntary organization. In any case, the committee should be made up of people who feel concern about the problem, have a sense of community responsibility, can inform themselves about the significance of the problem and who can present the problem to the people of the community so that they can make their wishes for action known to voluntary agencies and to governmental representatives. The committee should also pull together people and information so that as a group it will have a panoramic view of alcoholism in the community.

No Pattern of Management

No definite pattern of public health management of alcoholism has as yet emerged in the United States. At the national level the National Institute of Mental Health, as authorized by Congress, accepts responsibility for alcoholism in the areas of research, training and program development. Funds appropriated under the Mental Health Act may be used for alcoholism in these areas. A majority of states now have commissions, agencies or divisions within state departments to administer state programs. At the community level there are many varied activities, including clinics, operated by state agencies or locally, hospitalization plans and educational programs.

The lack of coordination of efforts at the local level is impressive. To coordinate the efforts in a community would require highly developed administrative skill and technical knowledge of alcoholism. In my opinion there are already resources in many communities to develop an organized community effort to control alcoholism. To pull the resources together so that they function with a maximum of efficiency and a minimum of wasted effort is a public health administrative problem yet to be solved. It will not be solved until people in

local communities are aware of the nature of the impact of alcoholism on their communities and express their wish that organized programs be established.

Summary

Alcoholism is a public health problem of major proportions. Because the etiology of alcoholism is still not known, a national program of prevention cannot be formulated. The public health approach, which is to provide organized community effort to combat disease conditions, is applicable to alcoholism. The objective of such efforts should be the rehabilitation of the alcoholic and his family. There are many community activities now assisting the alcoholic and his family but as yet no definite pattern of organization of these activities has emerged at the local level.

A Pledge for Kentucky Physicians

I do solemnly swear that I will make every effort to attend the 1960 KSMA Annual Meeting in Louisville on September 20, 21, and 22—and with this pledge, I promise to take immediate action by:

1. *Circling September 20, 21, and 22 on my calendar*
2. *Making arrangements for another physician to handle my practice*
3. *Writing for hotel reservations, if needed*
4. *Notifying patients that I will be out of the office for purpose of adding to my medical "know-how"*

Recognizing that the objective of the Association's Annual Meeting is to contribute to my medical knowledge by providing a varied, interesting and valuable program of postgraduate medical education, I hereby pledge myself to take an active interest in all scientific sessions, exhibits, and in all phases of the program leading to the advancement of the KSMA and the profession of medicine.

Building An Effectual Physician-Psychiatrist Team

Robert S. Garber, M.D., F. A. P. A.*

Belle Mead, N. J.

Psychiatrists should communicate in simple human terms, while generalists should learn they can manage some patients' emotional needs comfortably

PSYCHIATRY came into its own during World War II. It is to the credit of the medical departments of our military services that a radical reduction in the management of combat fatigue and other neurotic manifestations was accomplished, thereby preventing a tremendous accumulation of so-called "shell-shock" cases as was the experience following World War I. This resulted from a concerted effort on the part of the various medical specialties working toward a common solution and prompt recovery of these casualties. Such "togetherness" between non-psychiatrist and psychiatrists was actually the keystone of the success achieved, and it requires a renewal of such togetherness in civilian life, if we are to accomplish an effective management program for the innumerable psychiatric problems that confront the medical profession.

Need for Collaboration

The Journal of the American Medical Association recently has brought forth many articles of invaluable assistance to this cause: e.g., "Practical Steps for the Family Physician in the Prevention of Emotional Disorder"[1] by Gerald Caplan, M.D. The following is a quotation: "The style of work of the family physician is fundamentally different from that of a psychiatrist but the family physician who seriously wishes to enlarge the scope of his practical operations with respect to the mental health needs of his patients does well to build up a working relationship with a psychiatrist of his choice. This can greatly improve his ability to recognize emotional needs in families, to prepare married couples for emotional problems like those of pregnancy, to help families to go normally through periods of separation or bereavement, and generally to use his knowledge of the family in order to contribute to its stability. His traditional role brings him into contact with many people at times of crisis. At such times he can exert a particularly powerful effect on their mental health by steering them away from mal-adaptive solutions and towards adequate solutions of their life problems."

Mutual Respect

Thus, if we could learn to carry collaboratively problems that require joint management, and in such a fashion develop skill in "sharing" a patient where our combined skills can find a common solution, this would probably do more towards lessening the problems which exist between us than any other single factor. This is nothing more than emphasizing that there is a tremendous need for improved communication between professionals. We all need to develop mutual respect for the other man's role. Just as there is a need for an understanding by the psychiatrist of the range of problems with which the non-psychiatrist must deal, conversely there is a definite need for the non-psychiatrist to appreciate and understand that not every emotional problem must be routinely referred to a psychiatrist for resolution.

On the subject of consultations, Doctor Caplan, in the same article, makes an interesting observation, "In talking about consultations, I

*Medical Director, The Carrier Clinic, Belle Mead, New Jersey. Paper prepared for presentation at the 1959 Annual Meeting of the Kentucky State Medical Association in Louisville, Kentucky, September 22-24, 1959.

do not have in mind the occasional necessity to refer a patient with some psychiatric illness to a specialist for investigation and treatment. The kind of consultation I am particularly referring to here is different: It is consultation by the general physician with the psychiatrist specialist in order to enlist the latter's help in rendering the family physician's own understanding of the case and his own management of it more effective."

On the subject of "consultation, a two-way process," Doctor Caplan further refers to the fact as follows: "Working with the same psychiatrist over a period of time, the physician may be able to teach him enough about the daily problems of general practice and the life situations of ordinary people who do not consider themselves psychiatric patients that he eventually can get answers which come reasonably close to being useful." There is an exceedingly fine collection of ideas offered in this article and all physicians would do well to read it thoroughly.

Effective Communication Needed

Psychiatrists need also to develop an ability that will enable them to relate comfortably and easily to other physicians in simple, understandable, human terms so that they do not overwhelm the non-psychiatrists with highly technical discussions of the mental mechanisms involved in the dynamics of illness. Questionnaire surveys secured in the far west, the middle west, and eastern seaboard consistently reported the fact that the generalist is most offended when his psychiatric consultant persists in using unfamiliar psychoanalytic terms.

Since a psychiatrist is called upon usually when the family physician is confronted with an emergency and, since there is the need to aid in the management of the physician's anxiety as well as the family's anxiety over such a situation, clear communication is vital. One might refer to the article titled "Panel Discussion on Psychiatric Emergencies in General Practice."[2] "In psychiatric emergencies either the patient or his family will generally demand immediate action. This pressure on the physician probably results in more mistakes than any other single factor. The state of acute anxiety or panic is unbearable but sedatives or tranquilizers provide merely temporary relief. The better the person's personal life is known to the physician the more intelligently can the crisis be handled. The psychiatrist in the community should be considered a resource to be called on when an emergency demands more psychiatric skill than the physician himself possesses."

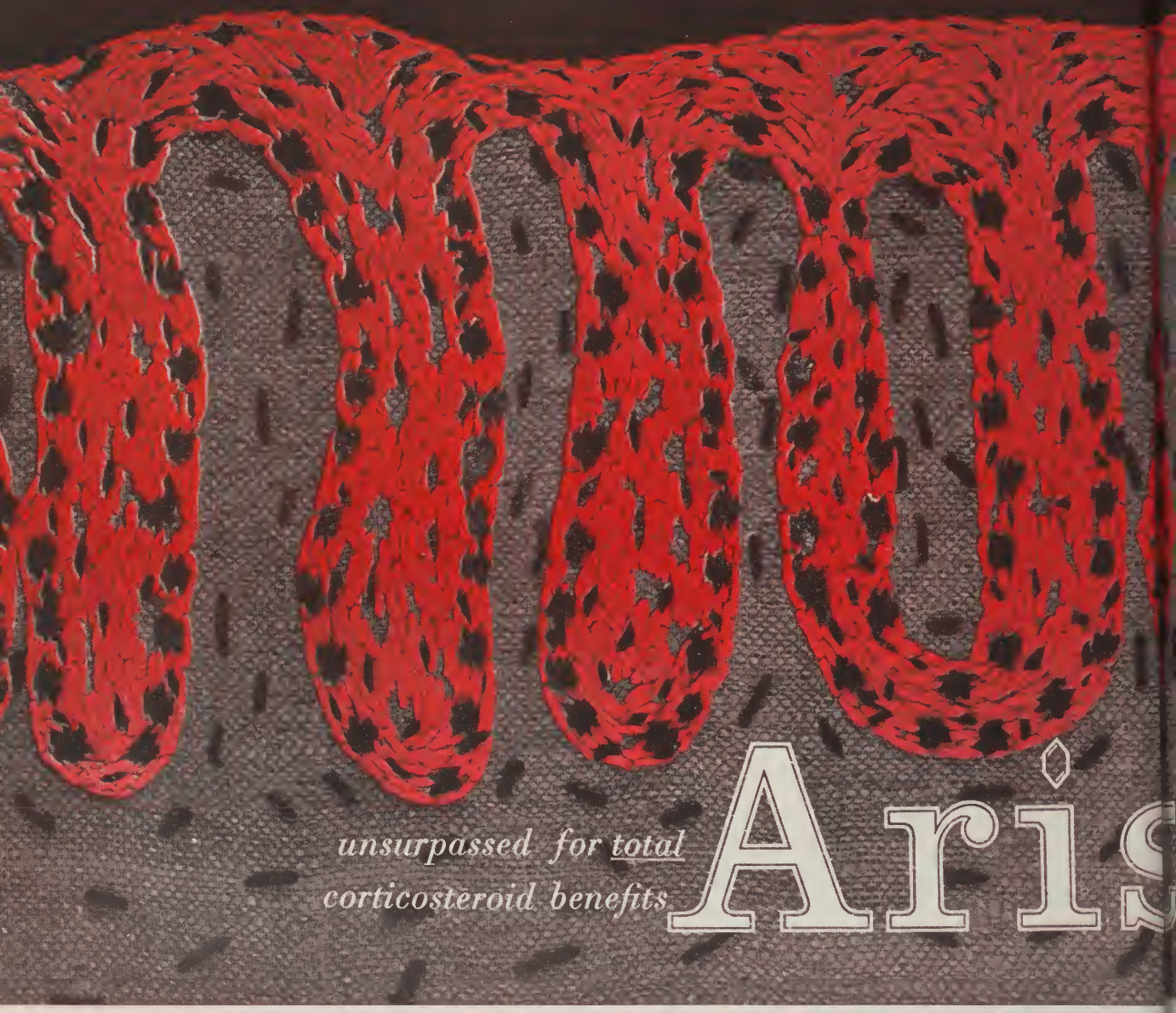
The necessity of building an effective relationship between non-psychiatrists and psychiatrists is found underlined by Wittson, et al, in their article "Psychiatric Problems and Preferences for Instruction,"[3] citing responses on 338 replies received from 1,200 practicing physicians and reporting that "the results of the study showed that communication between the two groups was not altogether satisfactory. General practitioners varied markedly as to the frequency with which they encountered or recognized psychiatric problems."

Lessening Misunderstanding

There is room on both sides for each group to begin making constructive efforts towards the lessening of their misunderstandings. Just as in the therapeutic management of any emotional conflict it becomes necessary for concessions to be made in both directions. The psychiatrist would do well to participate in more activities within his general hospital, within his county medical society, with a willingness to take on more in-patient and out-patient consultations, and make himself more readily available for hospital corridor discussions. Thus by his taking an active part in a variety of conferences within the hospital and within the framework of other specialties, there cannot help but result a satisfactory contribution of skills that will begin to mesh with those of a non-psychiatrist group.

In the other direction, officers and program chairmen of the County Chapters of the A.A.G.P. would do well to further these goals if they could capitalize upon the availability of qualified psychiatrists to come into their chapter meetings to further clarify points on which they desire information. The Liaison Committee between the Academy of General Practice and the American Psychiatric Association has already acomplished much in this direction and, no doubt, this has been the force behind the decision of the U. S. Public Health Service to establish scholarship grants for the general

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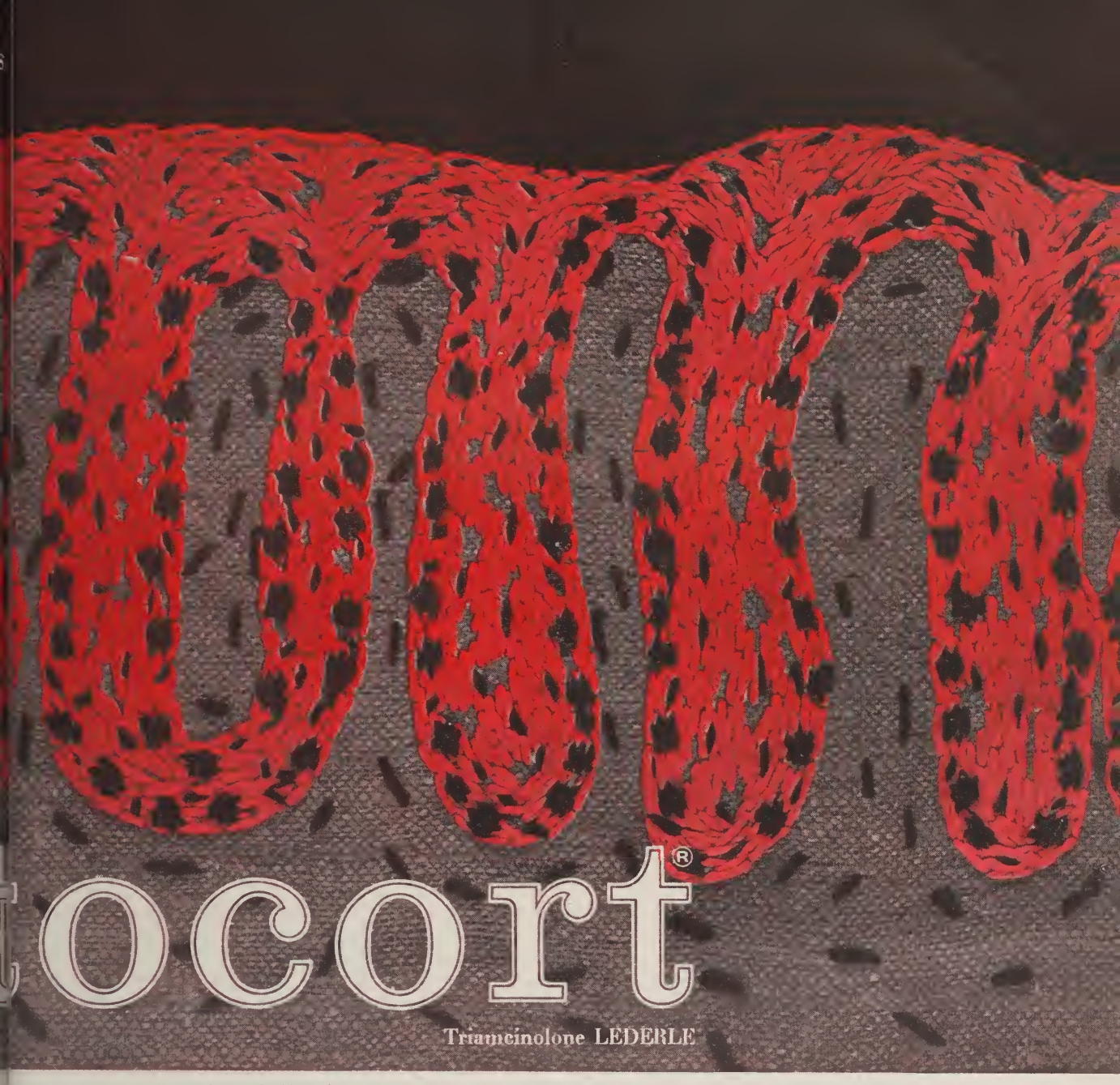
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Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

practitioner to embark upon a training program in psychiatry with a stipend to maintain his family. With the revitalization of a mutual aid program among ourselves such as existed during World War II, more effective management of the patient cannot help but occur.

Many psychiatrists are making themselves available for such requests by considerable flexibility in keeping a vacant hour in their appointment schedules at stipulated intervals for the purpose of meeting emergency demands. Others have found that they can meet such requests by encouraging the physicians to send patients in for a cursory survey of the situation, even though it may only mean a five to ten minute session. In areas where the mutual relationship has developed sufficiently, a telephone conversation will occasionally result in a conclusion that the patient should go directly to a psychiatric facility for admission rather than in the necessity for a formal consultation.

These, then, are some of the constructive efforts that are being made toward the attainment of such goals. It is most heartening to note the trend recently reported by the Editorial Board of the Journal of the American Medical Association. The report, "Medicine at Work," and the editorial, "Epidemology of the Future,"[4] certainly are worthy of your reading.

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Practice Of Surgery In A Neuropsychiatric Hospital

Psychotic patients present special difficulties in both diagnosis and treatment, yet 13 years of experience in a neuropsychiatric veterans hospital have shown that the presence of a psychosis does not alter the physical signs of disease and does not preclude the obtaining of a medical history or the administration of modern therapy. In surgical cases, preoperative management includes due preparation for all the experiences in the operating room; consent to operation has been refused only in extremely rare instances, and it is no longer necessary to struggle with patients to get them anesthetized. When the cooperation of a patient is needed for operations under local anesthesia, preoperative medication generally should be minimal. The postoperative course is usually uneventful, but it is necessary to remember that the psychotic patient seldom complains of pain, is not likely to be careful with tubes and catheters, cannot be counted upon to cough up secretions, and may attempt ambulation too soon.

The psychiatric behavior of the patient is especially important in orthopedic surgery because splints, casts, and traction apparatus may be tampered with or misused as lethal weapons by assaultive or suicidal patients. Trusses, braces, colostomy bags, and ambulatory urinals are unsuitable for most psychotic patients, and with patients potentially suicidal the triangular bandage, the elastic bandage, lengths of roller bandage or adhesive tape, as well as clips or safety pins, must be avoided. Difficulties with urination and defecation have frequently been found to be an expression of the psychosis itself, but the two functions interfere with each other in the sense that a greatly distended bladder has at times been found to prevent evacuation while in other cases fecal masses in patients with megacolon have caused urinary retention. Cataract extractions have been successful in 19 psychotic patients, with definite changes for the better in 10 patients whose improved vision greatly increased their capacity for self-care.

The presence of a full-time surgeon in a neuropsychiatric hospital has been shown to result in a low surgical mortality rate; it also is reassuring to the patients and their families.

—Walter E. Marchand, AMA Arch. Gen. Psychiat. (Aug.) 1959

The Forensic Pathologist—A Medical Detective

FRANK P. CLEVELAND, M.D.*

Cincinnati, Ohio

Forensic pathology is an accepted and essential medical specialty. Most important of its functions is protecting the community from unrecognized criminal acts

IN the practice of medicine today, one of the most important and perhaps least acclaimed physicians is the general pathologist. He has been defined as the doctors' doctor. For behind the scenes of all medical practice, there is the pathologist whose direction of the clinical laboratory daily serves the physician in the diagnosis and therapy of the patient.

The instant diagnosis by frozen section is accepted as a matter of routine. The culture of pathogenic organisms and the determination of the most effective antibiotic silently guides the attending physician in the more rapid recovery of his patients. Finally the post-mortem examination clarifies the obscure disease and provides data to help prevent other deaths from similar causes.

Cause of Death

In the performance of the hospital autopsy, the pathologist is concerned primarily in ascertaining the cause of death. He relates the clinical course of the patient to the signs and symptoms and correlates these with the anatomical progression of the disease. The purposes are to identify the disease process, to make the proper diagnosis for the attending physician and subsequently to educate the medical student, intern and resident. Education is a primary function of the post-mortem examination. Attention is given to the exterior of the body and any changes thereon as related to the disease. Surgical procedures are recorded for their effect upon the clinical course of the patient and for their functional aspects. The entire scope and language of the hospital autopsy are directed to persons having a medical background.

In the performance of the medicolegal autopsy, the purposes and requirements are viewed with the perspective of laymen. The autopsy, which may be completely satisfactory for the hospital and the attending physicians, may be entirely inadequate from the standpoint of the medicolegal requirements.

It must be recognized by all pathologists that the requisites of the medicolegal autopsy are entirely different than those of the hospital autopsy. Further, the protocol of the necropsy performed under legal authorization will rarely be used by physicians, but will be examined almost exclusively by lay persons having relatively little, if any medical understanding. These persons are the coroner, prosecutor, defense attorney, police investigators and finally, the lay jury. The latter oftentimes has the ultimate job of evaluating the facts, clearly and concisely presented, contained in the protocol of the medicolegal autopsy.

In any instance where the pathologist performs an autopsy in a suspected homicide, not only must he clearly establish the cause of death, but he may be expected also to provide data that could establish the identity of the deceased person, to record observations that will help to ascertain the time of death,

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to evaluate the characteristics of the injuries in terms of the instrument with which the wounds were inflicted; and to preserve any and all miscellaneous items — clothing, hair, fingernail scrapings, blood and similar items, which may at some future time aid in the identification of the criminal.

The medically accurate and descriptive post-mortem report that is completely understood by the attending physician can be incomprehensible to the homicide detective and to the prosecuting attorney. These individuals may literally spend hours and days examining the information for some clue or correlating fact to substantiate evidence already collected. If the autopsy fails to meet the needs of the individuals who must use it as a part of their daily work, then the inadequancy of the examination soon becomes apparent to all concerned. The post-mortem examination performed by competent hospital pathologists who do not make a description of surface injuries readily observed in both the police and pathologists' photographs needs no comment pertaining to the questions of competency which will be raised by the criminal attorney.

Healthy Suspicion

The pathologist who performs the medico-legal autopsy must be akin to the homicide detective. He must maintain a healthy suspicion concerning all deaths, particularly those in which after completion of the examination there is no obvious anatomical cause of death. Herein the specialized training of the forensic pathologist prepares him for the future problems with which he will be faced.

For the pathologist who examines the scene of a crime, there are the particular items whose value would be recognized only by a physician. As an example: in the case of death following a criminal abortion, there was noted to be a peculiar odor emanating from the genitalia of the deceased. The pathologist recognized the odor as being that of iodoform. Later, an official search of the premises in which the death occurred disclosed, within each of the treatment rooms, an unlabeled brown bottle containing a soapy liquid having a similar odor. These items were retained by the investigators at the suggestion of the pathologist.

Subsequent post-mortem examination revealed a soapy solution behind the placenta within the uterus. Samples were taken from the uterus, heart and lungs. Chemical analyses of the various fluids obtained revealed the presence of iodine and a sodium soap which was shown conclusively to have the same components, except for the degree of dilution, as the liquid found in the offices of the abortionist. Animal experimentation established the intravenous toxicity of the iodine-soap mixture.

So well founded and conclusive was the evidence that when the suspect was brought to trial, he pleaded guilty on the advice of his attorney. There is little doubt that if the search of the scene had been left entirely in the hands of the lay officers, these important items of evidence could very well have gone unrecognized.

Importance of Clothing

The hospital pathologist may never have the opportunity to see the clothes of the individual upon whom he performs the necropsy. These items are usually removed after the patient is admitted to the hospital. The forensic pathologist must of necessity examine the clothing as a vital part of the medico-legal autopsy. The clothing may contain residues of powder and smoke resulting from the proximity of the weapon. Such information is of vital importance in separating a homicide from a suicide or in confirming or refuting the story of a suspect who alleges that the gun was fired accidentally or unintentionally during a struggle.

An excellent example of the importance of the clothing is the following: a young woman was found murdered in an abandoned gravel pit. Tied around her neck was a white T-shirt, dirty and blood-stained. Also on the shirt was a considerable amount of grease. The suspect when apprehended was minus his shirt. Supplementary investigation disclosed that the suspect had repaired the refrigerator in his home on the day of the crime. Spectrographic and infra-red analyses showed that the grease from the shirt and from the refrigerator had the identical chemical composition. In face of such overwhelming evidence, the suspect gave a complete statement of the crime and was ultimately convicted of second degree murder.

External Examination

Ordinarily the exterior of the body is given a rather cursory examination by the hospital pathologist, unless the disease process (pemphigus, purpura or drug reaction) is such that the external manifestations are one of the cardinal features. To the forensic pathologist, the exterior of the body is one of the most significant phases of the examination. The characteristics of the external wounds will portray the physical structure of the weapon. A single bladed weapon produces an elongated wound having a rounded end or a pointed end; a double bladed instrument inflicts a wound having both ends with acute angles; an ice pick leaves a small, oftentimes overlooked, oval defect resembling a superficial abrasion.

To illustrate the point, a young woman found murdered in her room had numerous stab wounds resembling two closely approximated triangles roughly forming a square. The weapon was later identified as being a pair of barber's scissors. In addition, on both sides of the neck there were observed to be many small linear and crescent superficial abrasions of recent origin. Police investigation established that on the day prior to the murder the deceased had been attacked by her lover and he had attempted to strangle her. This information was confirmed by the post-mortem examination.

Internal Injuries

The forensic pathologist is constantly amazed by the degree of injury that the human body can sustain internally without any visible external signs. A severe blow to the abdomen can rupture the spleen or lacerate the liver with fatal hemorrhage and yet no evidence of injury is visible. Death following abdominal injury may occur suddenly, or several days or weeks after the incident as the result of contusion of the intestine, subsequent rupture and fatal generalized peritonitis.

Persons found dead in unusual locations at necropsy have been observed to have completely severed abdominal aortas and vertebral fractures without any external signs of injury. Such massive trauma can only result from the body having been struck by an automobile. The clothing protects the body from obvious external marks and death is so rapid as to prevent the hemorrhage from appearing on the surface as either a bruise or ecchymosis.

The attending physician accepts all patients as being honest and maintains sincere confidence in the doctor-patient relationship. Rarely does he suspect either the patient or relatives of ulterior motives. Thus, the family doctor is the last person to suspect foul play. Consequently, homicidal poisoning is infrequently considered in the differential diagnosis of a difficult case.

Complete Necropsy Often Vital

As a hospital pathologist who has just completed a necropsy, how often does one seriously consider death from unnatural causes. It is always possible to find a little arteriosclerotic heart disease or chronic pyelonephritis or some other condition which may be listed as a cause of death, even though the pathologist cannot thoroughly convince himself that such disease in reality caused death. Or else, the pathologist can, in all honesty, state that the cause of death is undetermined. Many times a completion of the necropsy would provide the mechanism or disease leading to the fatality.

In certain age groups, one invariably examines the larynx for the inflammatory lesion leading to obstruction and asphyxia. However, the neck should be dissected in every autopsy, for obstruction by foreign objects (bolus of meat, chewing gum, plastic or rubber balloon) can and does occur more often than is generally realized. The acute obstructive laryngitis may occur in adults as well as infants. Without examination of the neck organs, all one may find is pulmonary edema of undetermined origin and acute hyperemia of the viscera.

Diagnostic Error

The errors of diagnosis that result when the death certificate is signed by the coroner without the benefit of the post-mortem examination are known only to the forensic pathologist who is later consulted. In a recent case, a man 65 years of age was found dead in his car immediately after the occurrence of a collision. All physicians, and pathologists in particular, should recognize that there are only a very, very few conditions which will produce instantaneous death. An examination of the ex-

terior of the body by the coroner revealed only minor contusions and abrasions of the scalp, shoulder, arms and legs. There were no external injuries which anyone would associate with death resulting from trauma. Consequently, the coroner signed the death certificate "Coronary thrombosis, myocardial infarction."

Several days later, just prior to the body's being interred, the family lawyer raised the question of how the exact cause of death could be determined. A post-mortem examination disclosed the injuries as previously mentioned, generalized arteriosclerosis and miscellaneous other conditions consistent with the age of the individual. Examination of the neck organs failed to show a cause of death. Dissection of the cervical vertebrae and examination of the cervical spinal cord from a posterior approach showed fracture and dislocation of the first and second cervical vertebrae and crushing injury of the cervical spinal cord. There was no hemorrhage inside of the dura mater although suspicion was raised by the petechiae in the segment of spinal cord below the medulla.

Only a high cervical spinal cord injury could account for the instantaneous death of this man. The hazard of either no autopsy or an incomplete necropsy can be readily recognized.

Pathology can be the most fascinating type of medical practice; it allows the pathologist to exercise ingenuity and imagination, it requires study, concentration and diligent search. Its rewards are the diagnosis of a difficult disease or tumor, the initiation of therapy for the patient and the provision of a needed service to medical colleagues.

Forensic pathology has similar requirements and rewards. There is the recognition of an unsuspected murder or of death from unusual disease or injury. There is the satisfaction of obtaining from the dead human body the story of the cause, mode and manner of death for the edification of medical colleagues and for the protection of the community.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 40 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

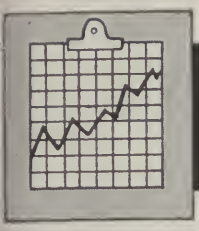
Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The Bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 1169 Eastern Parkway, Louisville, Kentucky.



CASE DISCUSSIONS
From The
University of Louisville Hospitals



Louisville Child Guidance Clinic

Childhood Anxiety*

LINDA, 5 years, 10 months old, was referred to the Clinic for treatment by her pediatrician because of her extreme timidity. She was afraid of everything, trembling with fear in kindergarten and in the doctor's office. From early years she did not play with other children. Mother thought she was retarded because of her excessive crying and general immaturity. She was "mean" to her younger brother and could not be left alone with him.

Medical History and Development:

Linda was in good physical health at the time of referral. Delivery was normal; birth weight 7 pounds 10 ounces; breast fed with supplementary formula. She had several minor respiratory infections until 18 months, during which time mother was unduly alarmed. There were several attacks of acute tonsillitis with cervical adenitis from age 4 to 5.

There was no difficulty with weaning. Toilet training started at six months; bowel and bladder trained before age 3. She walked at 14 months; talked somewhat late, which brought mother's concern that Linda was retarded. Parents were coercive early, so that at age 2 she knew she could not touch such things as ash trays, etc. From age nine months to 3 years she would occasionally hold her breath and turn blue when she did not get her own way.

Family Constellation:

Brother—age 4; half-brother—age 20, living in the home; half sister—age 24, married, living out of the home; father—age 40, from well-to-do family, considered the family's "black sheep"; eldest of 4 children; shy, kind, affectionate, little initiative; not successful in his work.

Mother—age 42, persistent, apprehensive, unhappy, somewhat "mousy." She was raised on a farm, the third of five children. She lost her mother when she was 8. She and her sister stayed with her father; the other siblings going to the grandparents. She missed her mother so intensely that she could hardly speak of her in the clinic interview without crying. Her first marriage was unhappy because her husband treated her cruelly. She left the first husband when her children were small and went home to her father who was devoted to the children. The first six years of her second marriage were happy. However, her husband's several job changes provoked a growing feeling of insecurity.

Mother's Attitude:

Mother had little understanding of what to expect of a child of Linda's age and feared she was retarded. She was concerned over Linda's open signs of jealousy toward her little brother. She was disappointed by Linda's "lack of responsibility" in personal habits such as washing hands or brushing teeth. Mother was terrified when she learned that a short time before coming to the Clinic a neighbor boy had exposed himself to Linda and wanted her to do the same. Mother had difficulty talking about this and wondered if Linda was "over-sexed." She subsequently watched the two youngest children carefully, knew every minute where they were, and found it impossible to meet the child's questions about sex.

Mental Status:

Linda was slender, rather plain looking, and showed much apprehension. She rarely smiled and met the examiner with distrust and suspiciousness.

From Psychologist's Report: "Linda flatly refused to make a move without her mother coming along. She appeared immensely frightened, and met the threat of the test by non-compliant behavior. On the vocabulary, she would say, "I don't know" to every question. The projective tests elicited little because of her excessive anxiety. Linda was functioning psychometrically in the dull normal category (IQ 86).

Therapy With Mother:

In the early interview, mother preferred to discuss her own life and all the trouble with her husband and her first-born children rather than to focus on Linda. In later interviews, however, she could concentrate on her own feelings regarding her little girl,

Presentation by Lotte Bernstein, M.D., Associate Professor of Psychiatry and Clinical Director, Louisville Child Guidance Clinic.

but first she had to unburden herself. She was then relieved of some of her tension and could loosen some of her rigidity. She especially needed help when Linda became more aggravating at home as a result of her play sessions at the Clinic. Gradually mother could enjoy planning activities with the two youngest children. She could, also, accept the therapist giving Linda simple explanation of sex.

Play Therapy With Linda:

After many weeks, Linda could believe in the freedom of the Clinic playroom and dare to do things herself. In her play activity she "killed" many people because they were "bad." She always wanted to take something home from the Clinic.

We learned that Linda's timidity and restricted behavior served as a protection against strong impulses and desires that met disapproval especially in the first two years of her life. She filled the baby bottle in the playroom with water and sucked with ecstatic intensity. Gradually, she enjoyed messy play with finger paints and wet clay. She moved from this to more organized play with doll furniture as her tension had relaxed.

She had several play sessions in which something killed a baby brother. When communication was well established, the therapist took up with her all the questions and confusions which had troubled her—her feelings toward the baby brother, her reactions toward mother's rigid and watching attitude, her confusion about the difference between boys and girls.

The therapist's approach to Linda provided experiences which were quite different from those at home. He believed in her abilities, and his faith in her encouraged her to try out her own ways of handling situations instead of being dependent on his care. She tested his sincerity saying, "Is it O.K. if I mess the floor up?" The answer was, "Sure, and at the end we will clean up together." Through sex education she learned that knowledge is neither dangerous nor a sin. Her most significant experience was with the therapist's conviction that she was not "bad"—one of the words she used most about herself.

At the end Linda had lost her timidity and became a much happier, self-confident child. Her relationship with other children improved considerably. Later a follow-up at school confirmed that she could accomplish according to her age.

Discussion:

Dr. Spafford Ackerly: The intensity of Linda's impulses, her persistency and her difficulty in giving up her personal desires must have threatened mother's rigid personality and were contrary to her moralistic attitude. Linda's birth was definitely the end of the carefree years of mother's second marriage. It coincided with father's difficulties in getting jobs. Mother's growing feeling of insecurity made her too preoccupied with her own worries to listen to Linda's needs. She perceived her as "retarded" and "bad" when Linda did not conform with her preconceived notions and increasingly rigid regimentations.

Dr. John Ice: We know very little about the father, but we see that the younger brother was evidently easier to handle. He seemed to have fulfilled much better mother's dreams and she preferred him. This may have forced Linda to look upon herself as inferior. She became afraid of her strength and persistency and frightened by her impulses and her anger at mother and brother. She expected retaliation for her anger. The result was a paralyzing, inhibiting effect on her total personality, leading to an appearance of retardation.

Dr. Lovick Miller: This case demonstrates clearly the crippling effect childhood anxieties may have for the development of personalities. All children have times of fears because there are constantly new situations which sometimes appear overwhelming before the child learns to master them. It is of great importance how the adult meets these anxieties and fears. If he will approach the child with understanding and support, enlarging the child's knowledge of the surrounding world, he will help the child to grow and to conquer the difficulties. Otherwise we see the danger of the child's withdrawal into his own world where fantasies replace reality.

Men love to wonder, and that is the seed of science.
—Emerson

SPECIAL ARTICLES

A Contrast And A Plea

OUR purpose in submitting this article is to show the contrast between Forand-type legislation and our own recently-enacted Kentucky indigent-care program, and the philosophy back of each. In addition, we appeal to you for your thoughtful and effective cooperation in discharging fully our responsibility as physicians, especially as they relate to our indigent-care program.

The Forand Bill—HR 4700—designed as sure vote getter this presidential election year, would provide hospital, nursing-home and medical-care coverage to all clients of the Social Security system and their dependents, 65 years and older—about 16 million people. This bill would not cover the majority of the indigent elderly; it would glut hospitals, and would cause an increasingly high tax burden. It is a program of compulsion, and the first big step to socialized medicine.

The Kentucky State Medical Association, which has been supporting indigent medical-care legislation since 1954, in cooperation with the other four members of the Kentucky Allied Council on Medical Service sponsored a carefully written bill with controls to guarantee the equitable operations of the program in the 1960 Kentucky Legislature. With the excellent support of the Combs administration our bill became law.

Many physicians, members of allied medical groups and others have worked an unbelievable number of hours carefully wording and outlining a program that will provide only the necessary amount of medical care to Public Assistance indigents who are now receiving the essential food, clothing and shelter. The law specifies that an 11-member state advisory council be appointed to advise with the Departments of Public Health and Economic Security in conducting the phases of the program that each agency is to perform.

The predominately allied medical group council will advise with the two departments in defining their joint responsibilities as well as each department's individual duty. The Department of Economic Security will be charged with the responsibility of securing federal funds, certifying eligible recipients and dispensing of the funds. The Department of Health will be charged with all matters related to medical care. To do this, the Commissioner of Health will establish a Department of Medical Care which will be directed by a physician.

Each of five allied medical groups and the Kentucky Nursing Home Association will have a five-member technical advisory committee. The purpose of these six technical committees will be that of presenting ideas to the 11-member state advisory council, which will meet at least quarterly. In order to obtain the maximum amount of medical care in each county from limited funds prorated to the county, a county review committee, composed of three physicians and one dentist, will decide the scope of the local program.

Our Committee and our Council of KSMA urge you as good physicians and good taxpaying citizens of Kentucky:

1. To participate in this program at whatever level you are asked—there is no financial remuneration.
2. To bring to bear your best judgment along with your eternal vigilance to secure service to indigent patients for a minimal expenditure.
3. And not to forget this could be our last chance in Kentucky to demonstrate that we in medicine can adequately do the job and at the same time properly use the taxpayers funds.

Committee on Medical Education and Economics

Gaithel L. Simpson, M.D., Greenville, Chr.
John Quertermous, M.D., Murray
O. Leon Higdon, M.D., Paducah
John Dickinson, M.D., Glasgow
Claude C. Waldrop, M.D., Williamstown

EDITORIALS

Ulcerative Colitis – A Precurser Of Malignancy

ULCERATIVE colitis is a chronic debilitating, premalignant disease, many times leaving its victims with marked functional incapacity. All too often the disease begins at an early age, curtailing the most productive years of its victim. Actually, the etiology of ulcerative colitis is unknown; however, bacteria, viril organisms, chronic trauma and allergic reactions have often been suggested as causes. None of the aforementioned have ever been incriminated.

Symptoms and Clinical Course

This disease frequently begins in the second or third decade and is usually ushered in by symptoms suggestive of gastroenteritis and accompanied by recurrent and intermittent episodes of diarrhea, abdominal pain of a cramping nature, weight loss and fever. As the disease progresses in severity, the diarrhea becomes the most prominent complaint, frequently associated with gross blood loss, which may occur early in the disease. Anemia, with attendant weakness and weight loss, occurs secondarily.

During active episodes of colitis, the patient will frequently complain of abdominal pain and tenderness. Physical findings may not be too outstanding, though usually after prolonged illness, there is gross evidence of anemia, malnutrition and weight loss. X-ray findings are: shortening of the colon, ulceration, loss of haustrations, stenosis, s t r i c t u r e formation, pseudo-polyposis and, occasionally, frank changes suggesting carcinoma. Sigmoidoscopic findings vary, depending upon the stage of the disease. Usually ulcerations can be demonstrated. Necrosis, friability and bleeding may be observed. Stenosis may occasionally be seen in the upper rectum.

The complications of this disease are numerous and, as pointed out by Ferguson, the commonly accepted indications for operation are, in fact, an enumeration of the complications of the disease. This simply indicates that perhaps we wait too long before operating on these people. The usual complications of ulcerative colitis are: hemorrhage, obstruction, perforation, fistulization and carcinoma. The most common locations for fistulae are: between colon and bladder, colon and vagina, and colon and skin, usually in the perirectal area. Some of the far-reaching complications of ulcerative colitis include septic arthritis, pyoderma gangrenosum of skin, pulmonary disease in the form of abscess, and iritis.

Treatment

This disease is generally one which is felt to begin in the rectum and spread proximally to involve the entire colon. However, there have been many cases of segmental ulcerative colitis reported. When this occurs, it is usually said to begin in the right colon, extending in either direction with skip areas being fairly common, as reported by Donald. In any event, a large number of these people eventually come to surgery. Bacon, in a series of 322 cases, found it necessary to subject 21.9% to surgical intervention.

It is now a fairly well established fact that the incidence of carcinoma in this disease increases proportionately with the duration of symptoms. Bargan, in 1954, in a study of over 1,500 people with ulcerative colitis, found that the incidence of carcinoma was thirty times more frequent than in people of the general population in a given age group. Lyons, in a study of 226 surgical cases, found that in patients in whom the disease has existed 12 years or longer, the incidence of carcinoma was 36%.

Medical treatment largely consists of diet, antibiotics, supportive measures, the use of steroids and psychotherapy. There have been some prolonged remissions reported in the use of steroids, particularly where the disease is treated vigorously in the early stages.

Surgical treatment of this disease at the present time, and with few exceptions, consists of a one-stage proctocolectomy and ileostomy. The practice of leaving the rectal segment in, with later performance of an ileorectostomy, is to be condemned, as many complications have resulted from this technique. This was noted in a series of cases observed by Mayo in 1956. In selected patients, as pointed out by Hill, it is possible to remove almost all rectal tissue from above, obviating a lengthy perineal operation.

In the past, the largest number of postoperative complications have directly stemmed from the ileostomy. The major complications being: stenosis with obstruction, retraction of the ileostomy, and prolapse of ileum. Also, fistulization around the ileostomy has been quite commonly reported. The incidence of these complications has been greatly reduced with the advent of the Brooks-type ileostomy, first described by Mr. Brooks in 1952. This operation essentially consists of maturation of the ileum by eversion and suturing of mucosa to the skin.

The following is a case report of ulcerative colitis of at least 13 years' duration, in a young man, with the development of carcinoma in the cecum.

The patient, G.D.C., is a 35-year-old dolly driver who was admitted to Kentucky Baptist Hospital, Louisville, Kentucky, on January 7, 1959, with a chief complaint of bloody diarrhea and weakness.

The patient gave a history of diarrhea, dating back 13 years and becoming steadily worse in the interim. In recent years, his diarrhea has been almost constant with gross blood being noted quite often in his stools. In 1958, it was necessary for the patient to be transfused because of marked anemia. He has lost many days from work because of weakness, lethargy and intercurrent infection. He estimates that shortly before his last hospitalization, he was having from 10 to 15 bloody, loose bowel movements per day.

His past history indicates that he was operated on for appendicitis at an early age and apparently shortly thereafter developed an abscess for which he was reoperated. In November of 1947, approximately 12 years ago, the patient was admitted to a hospital in Ohio with a diagnosis of bacillary dysentery. During his stay there, he was sigmoidoscoped and a barium enema was done. A diagnosis of ulcerative colitis was then made. Barium enemas were again done in Louisville, Kentucky, as an out-patient



Fig. 1

A barium enema done on 35-year-old patient revealed the characteristic loss of haustrations and narrowing of the bowel in segments. A filling defect in the cecum was also observed.

in 1953 and 1957, revealing diffuse involvement of the colon and narrowing in the sigmoid segments.

Physical examination on admission to Kentucky Baptist Hospital revealed a somewhat undernourished, pale-appearing white male with some tenderness to deep palpation in his abdomen. Otherwise, he appeared to be in good general condition. Sigmoidoscopic examination shortly after admission revealed the presence of thrombosed external hemorrhoids; the rectum exhibited areas of frank necrosis with diffuse ulceration and bleeding on manipulation of the scope. There was stricture formation noted at 10 cm and it was impossible to pass the sigmoidoscope further. A barium enema was again done on January 9, 1959, (Figure 1), re-

vealing the characteristic loss of haustrations and narrowing of the bowel in segments. A filling defect in the cecum was also observed. A chest X-ray was entirely negative.

Laboratory studies on admission revealed a hemoglobin of 8.3 gms.; hematocrit of 28%; RBC, 3,180,000. A WBC and differential were within normal limits. Urinalysis revealed one plus albumen. Serum potassium was 5.5 mEg/L; serum sodium, 147 mEg/L; serum chlorides, 107.5 mEg/L; serum calcium, 7.05 gms. Total proteins were 5.8; albumen 3.45; globulin 2.35. A VDRL was negative. His prothrombin time was 100%. Medical consultation was obtained shortly after admission and the medical consultant felt that, in view of the far-advanced nature of the disease, surgery was indicated. The patient was transfused until his blood count was normal and his electrolytes were corrected. He was taken to surgery on January 15, 1959, at which time a total proctocolectomy and ileostomy were performed. On opening the specimen, the patient was found to have a papillary mucous-producing adenocarcinoma of the cecum, grade two, which had infiltrated the wall of the bowel. There was no evidence of metastasis in the lymph nodes. A plastic ileostomy appliance was fitted to the ileostomy on the first postoperative day.

The patient's postoperative course was entirely satisfactory and he was discharged on the fifteenth postoperative day. He is now approximately 17 months since surgery and has gained 27 pounds in weight. He is working regularly and states that he now has more strength than he has had in years. He engages in many activities and has had no difficulty whatsoever with his ileostomy.

Summary

Though one cannot predict which patient with ulcerative colitis will develop cancer, it is a safe bet that if he has had the disease for twelve or more years, his chances are roughly one out of three. This risk, coupled with the attendant disabilities inflicted by the disease, should make us more aware of the benefits derived from surgery and less reluctant in suggesting it to our patients.

Harvey C. Hardegree, Jr., M.D.

OPEN MEETING

Council of Kentucky State Medical Association

South Room
Brown Hotel

10 A.M. Thursday
July 28, 1960

Louisville, Kentucky

The Council invites interested KSMA members to attend

ORGANIZATION SECTION

13 Top Medical Specialists Booked By KSMA As Guest Speakers At 1960 Annual Meeting Scheduled For Sept. 20-22 In Louisville

Thirteen top-ranking medical specialists of the nation are scheduled to appear on the program of the 1960 Annual Meeting of the Kentucky State Medical Association, announces KSMA President Irvin Abell, Jr., M.D., Louisville. Representing diversified interests in the field of medicine, they will also be the guest speakers at separate sessions of Kentucky's specialty groups.

The three-day event is set for September 20, 21 and 22 at the Columbia Auditorium in Louisville.

Six of the specialty groups will meet on Tuesday afternoon, September 20, to hear the following essayists:

Kentucky Society of Anesthesiologists—**E. M. Papper, M.D.**, New York, lecturing on "The Use Of Tranquilizers In Surgical Patients." Doctor Papper is director of the Department of Anesthesiology at the Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York. The author of some 124 published scientific papers, he is currently doing research on the pharmacology of anesthetic agents and the physiology of circulation during anesthesia.

Kentucky Chapter, American College of Chest Physicians—**Michael L. Furcolow, M.D.**, Kansas City, Kan. Doctor Furcolow is chief of the Kansas City Field Station, Epidemiology Branch, Communicable Disease Center, and associate clinical professor of medicine at the University of Kansas School of Medicine.

Kentucky Obstetrical and Gynecological Society—**William F. Mengert, M.D.**, Chicago, speaking on "Radiation Hazards In Obstetrics." Professor and head of the Department of Obstetrics and Gynecology at the University of Illinois, College of Medicine, Doctor Mengert is also chairman of the Department of Obstetrics and Gynecology at Parkland Memorial Hospital.

Kentucky Orthopaedic Society—**Paul Williams, M.D.**, Dallas, Texas, discussing "Conservative Management Of Lesions Of the Lumbosacral Spine." Doctor Williams' research at the present time is concerned with lesions of the lumbosacral spine and degenerative arthritis.

Kentucky Chapter, American Academy of Pediatrics—**Irving Schulman, M.D.**, Chicago, presenting a paper on "Recent Concepts In the Treatment Of Purpura." Doctor Schulman is professor of pediatrics at Northwestern University Medical School and director of hematology at the Children's Memorial Hospital, Chicago. He is now doing research on platelet stimulating factors in human plasma, phospholipids as platelet substitutes, and the function of the spleen in regulation of blood formation.

Kentucky Chapter, American College of Surgeons—**Jonathan E. Rhoads, M.D.**, speaking on "An Evaluation Of the Whipple Operation For Carcinoma Of the Pancreatodoudenal Region." Doctor Rhoads' principal appointments are John Rhea Barton professor of surgery and chairman of the Department of Surgery, School of Medicine, University of Pennsylvania, and director of the Harrison Department of Surgical Research at the university.



Dr. Papper



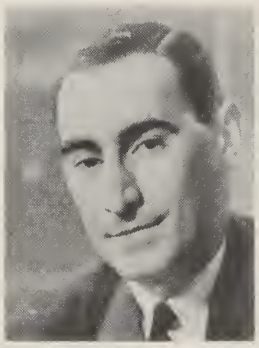
Dr. Furcolow



Dr. Williams



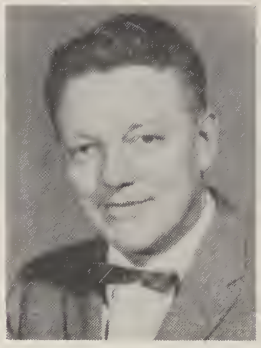
Dr. Mengert



Dr. Schulman



Dr. Rhoads



Dr. Larson



Dr. Busse

Speakers for Sept. 22

Speakers for seven other specialty groups, meeting on Thursday morning, September 22, will be:

Kentucky Chapter, American Academy of General Practice—**Nicholas W. Fugo, M.D.**, Chicago. Associate professor in the Department of Obstetrics and Gynecology, University of Chicago, Doctor Fugo is doing research in the physiology of reproduction.

Kentucky Society of Pathologists—**Charles P. Larson, M. D.**, Tacoma, Wash., director of laboratories for Tacoma General Hospital and co-owner of private laboratories in Tacoma. The topic of his presentation will be "Miscellaneous Medical Legal Problem Cases."

Kentucky Chapter, American College of Physicians —**Julian M. Ruffin, M.D.**, Durham, N. C., professor of medicine at Duke University.

Kentucky Psychiatric Association—**Ewald W. Busse, M.D.**, Durham, N. C., lecturing on "The Psychiatric Aspects Of Aging." Doctor Busse is professor of psychiatry and chairman of the Department of Psychiatry, Duke University Medical Center. His current research projects are concerned with the human aging process.

Kentucky Public Health Physicians—**Alexander D. Langmuir, M.D.**, Atlanta, Ga., chief of the Epidemiology Branch, Communicable Disease Center, Atlanta, and associate clinical professor of preventive medicine and community health, Emory University School of Medicine.

Kentucky EENT Society—**A. C. Furstenberg, M.D.**, Ann Arbor, Mich., speaking on "Nasal Obstruction —Its Diagnosis and Management." Doctor Furstenberg is dean and professor of otolaryngology at the University of Michigan Medical School.

Kentucky Radiological Society—**John A. Campbell, M.D.**, Indianapolis, presenting a paper on "Clinical Applications Of Cineradiography." Doctor Campbell, who holds the post of professor and chairman of the Department of Radiology, Indiana University School of Medicine, is doing research in cineradiography, minification of roetographic images and reduction of radiation exposure in diagnostic radiography.

Meanwhile, plans for other features of the Annual Meeting are moving on schedule.

Arrangements are complete for the transatlantic telephonic conference Wednesday afternoon, September 21, in which the Bromley Division of the British Medical Association will participate with KSMA in the first conference of this type ever staged by a state medical association. The hour-long program will follow the CPC format.

All available space for technical exhibits has been sold to carefully-selected companies, according to John D. Allen, J., M.D., Louisville, chairman of the committee in charge. The Committee on Scientific Exhibits, headed by J. Thomas Giannini, M.D., Louisville, is working hard to present a worth-while program.

As previously announced, the Association will have the privilege of hearing John B. Reckless, M.B., Ch.B., of Durham, N.C., at the President's Luncheon Wednesday, September 21.

Separate Reunions Are Planned For Medical Graduates

Instead of the one alumni dinner customarily given as a part of the KSMA Annual Meeting program, separate reunions are being planned this year for graduating classes of the University of Louisville School of Medicine, according to George F. McAuliffe, M.D., Louisville, president of the school's medical association. Scheduled to celebrate are the classes of the years ending in 5 and 0, starting with 1915.

A golden-anniversary luncheon for 1910 graduates also is being arranged.

Les Shively, director of alumni relations at the U. of L., reports that several of the classes have chosen the Pendennis Club for their reunions. The class of 1915 will have a dinner there on September 21; the 1950 alumni, a dinner dance on September 20, and the class of 1955, a cocktail party on September 21. Plans of other classes were incomplete at the time The Journal went to press.

New KSMA Members Listed

Physicians who have enrolled as members of the Kentucky State Medical Association since The Journal's last report include:

Glenn Louis Pfister, M.D., Fort Thomas
R. Burke Suitt, M.D., Harlan
Paul H. Wilson, M.D., Franklin



Dr. Askey



Dr. Larson

AMA Elects Dr. Larson, Bismarck Pathologist

Leonard W. Larson, M. D., 62-year-old pathologist of Bismarck, N. D., was named president-elect of the American Medical Association on June 16 at the group's Annual Meeting in Miami Beach. He will be installed at next year's meeting in New York City.

Inaugurated as president was E. Vincent Askey, M.D., 64, Los Angeles surgeon, who succeeded Louis M. Orr, M.D., Orlando, Fla. Doctor Askey served as speaker of the AMA's policy-making House of Delegates from 1955 to 1959. As the 114th president of the AMA, he is the spokesman for more than 175,000 physicians.

Doctor Larson has served on the AMA's Board of Trustees since 1960. He was a member of the AMA House of Delegates from 1940 to 1950, representing the Section on Pathology and Physiology. The House elected him a member of the Council on Scientific Exhibits.

He was chairman of the Commission on Medical Care Plans which, after four years of study, submitted its report to the House of Delegates. The House devoted six months of study to the so-called Larson report, approving it with slight modifications in 1959.

As a United States delegate to the World Medical Association for the past four years, Doctor Larson has attended meetings in Istanbul, Denmark and Havana. The 1960 meeting is scheduled in West Berlin in September.

Doctor Larson is known to many KSMA members, having participated in the 1957 Annual County Society Officers Conference in Lexington.

AMA Award For Distinguished Service Goes to Ohioan

Charles Doan, M.D., Columbus, Ohio, was the winner of the American Medical Association's Distinguished Service Award, presented June 13 at the opening session of the AMA's 109th annual meeting in Miami Beach. Doctor Doan is retiring dean of the Ohio State University College of Medicine.

The award has been given annually since 1938 to a physician who has made a notable contribution to the advancement of medical science. It consists of a gold medal and citation.

The recipient is selected by the House of Delegates from three physicians whose names are submitted by the Board of Trustees. Nominations for the award are made by the association membership at large.

TV Report On American Medicine Premiered At AMA Meeting

"Medicine USA," a special four-program television report on American medicine, was premiered on Station WCKT, Miami, as an additional feature of the American Medical Association's 109th Annual Meeting. The half-hour telecasts—part of the "Ask Your Doctor" series—are presented by Merck Sharp & Dohme, Philadelphia pharmaceutical house, in cooperation with the AMA.

The first program, "Report from Europe," is an on-the-scene review of the United States Information Agency exhibit which toured German cities early in 1960. The second program, "Twenty Years of Advancement," is a report of American medicine's progress during the past two decades. "Situation Critical" and "Course for Action," the other two programs in the series, are factual reports on the increased need for doctors in the United States and the problem of providing more medical schools.

The "Ask Your Doctor" television series is designed to keep the public informed on medical progress in the control, treatment and prevention of disease and to promote better understanding of the vital contributions made by the health team of the physician, hospital, pharmacist and drug manufacturer.

AMA's Color TV Programs Cover 17 Subjects

Physicians attending the 109th Annual Meeting of the American Medical Association in Miami Beach, June 13-17, saw live color television programs on 17 different medical subjects—from demonstrations with live poisonous snakes to chemical treatment of cancers and two surgical procedures.

The programs were televised daily by the medical color television unit of Smith Kline & French Laboratories, Philadelphia pharmaceutical firm, in cooperation with Mount Sinai Hospital, Miami Beach. Live telecasts, originating from the hospital, were projected to a large screen at the Miami Beach Auditorium.

The program marked SK&F's 12th year of medical color TV presentations. Last year the AMA cited the firm for its contributions to postgraduate medical education.

Because of the date of the 1960 AMA Annual Meeting and the striking airline pilots—it was not possible to carry a complete report of AMA meeting in Miami in this issue of The Journal. Reports of activities of the House of Delegates and other highlights will appear in the August issue.

KAGP's Big Sandy Seminar July 21 At Paintsville

The annual Big Sandy Seminar, sponsored by the Kentucky Academy of General Practice, is scheduled for Thursday, July 21, at the Paintsville Country Club. All physicians are invited to attend, it is announced by James W. Archer, M.D., Paintsville, and George P. Archer, M.D., Prestonsburg, co-chairmen of the event.

Dinner speaker will be Edmund A. Opitz, senior staff member of the Foundation for Economic Education, Irvington-on-Hudson, N. Y., who will talk on "Keystones of Freedom."

Registration will start at 1 p.m. (EST), followed by the scientific session at 1:55 p.m. Essayists and their subjects include:

"Diagnosis and Newer Concepts In the Treatment of Gynecological Surgery"—Philip S. Crossen, M.D., St. Louis.

"Peripheral Arterial Occlusion"—W. R. Wilkinson, M.D., Huntington, W. Va.

"Surgical Conditions of the Esophagus"—W. Burford Davis, M.D., Louisville.

"Surgical Management of Certain Types of Hearing Impairments"—Arnold B. Combs, M.D., Lexington.

The program has been submitted for four hours Category I credit.

A special program on flower arrangement is planned for the wives.

KSMA's 2nd Conference On Athletic Injuries Set For Aug. 13

The second annual Athletic Injury Prevention Conference, sponsored by the Kentucky State Medical Association, is planned for 9 a.m. Saturday, August 13, at the Guignol Theater (Fine Arts Building) in Lexington. Cooperating with the KSMA in presenting the half-day program are the Kentucky High School Athletic Association, Kentucky Advisory School Health Council and the University of Kentucky Athletic Association.

This year's conference, held in conjunction with the U. of K.'s annual coaching clinic, falls on the day of the East-West Kentucky High School football and basketball games for charity.

Subjects to be covered will include the prevention and treatment of knee, shoulder, head and musculoskeletal injuries and prevention and treatment of emotional aspects of athletic injuries, according to Carroll L. Witten, M.D., Louisville, chairman of the program.

Heart Group Elects Dr. Reardon

Marc J. Reardon, M. D., Covington, was elected president of the Kentucky Heart Association at its annual meeting in Louisville June 9. He succeeds Frank H. Moore, M. D., Bowling Green. Other physicians elected to office were Richard R. Crutcher, M. D., Lexington, first vice-president, and Edmund D. Pellegrino, M. D., Lexington, director.

Guest speaker at the meeting was A. Carlton Ernstene, M. D., Cleveland, president of the American Heart Association. Lack of research money is the bottleneck in the march of scientific knowledge, the internationally known heart specialist told the group. The AHA and its affiliate chapters spend nearly $10,000,000 a year for research, yet have to turn down worth-while requests, he said.

Dr. Beard Awarded $50,000 Grant For Leukemia Research

A $50,000 grant for research in leukemia has been received by Marion F. Beard, M.D., Louisville blood specialist, from the National Institutes of Health, Bethesda, Md.



Dr. Beard

Doctor Grant is an associate professor of medicine at the University of Louisville School of Medicine and chief of its section on hematology. He also is medical director of the Louisville Regional Red Cross Blood Center.

The two-year grant will enable staff members at the Medical School to test and modify drugs that may be used in treating certain types of leukemia, Doctor Beard said. Working with him on the project will be Thomas O. Stevenson, M.D., assistant professor of medicine, and Ellis A. Fuller, M.D., instructor in medicine.

Program Complete for Symposium At Glasgow July 18

Plans are complete for the symposium at Glasgow on July 18, sponsored jointly by the KSMA Sixth Councilor District and District Six State Tuberculosis Hospital. C. A. Wood, M. D., Auburn, president of the Sixth District, and Waller H. Griffing, M. D., Bowling Green, secretary, have worked with Malcolm H. Black, hospital administrator, in setting up the program.

Doctor Wood will preside at the meeting which will open at 6 p.m. with remarks by Eugen F. Puess, M. D., Glasgow, medical director of the hospital, and John P. Glenn, M. D., Russellville, Councilor of the Sixth District.

Representing KSMA, Richard F. Grise, M. D., Bowling Green, will present a scientific paper titled "Benign Lesions of the Colon." The hospital's contribution to the scientific program will be a "Review of Outpatient Bronchoscopy Clinic, Glasgow State Tuberculosis Hospital" by Nathan Levene, M. D., thoracic surgeon, and Julio Coelho, M. D., both of Louisville, and Doctor Puess.

Dr. Rumage Heads Chest Council

William T. Rumage, M. D., was recently elected to a three-year term as chairman of Louisville's Community Chest Council. William J. McGlothlin, Ph. D., of the U. of L. Medical School was named to a three-year term on the executive committee.

Dr. Hancock Cited for Service To Social Security Adm.

J. Duffy Hancock, M. D., Louisville, received a special citation for his services to the Social Security Administration and to the medical profession during the 10th meeting of the National Medical Advisory Committee which gives professional medical guidance in the operation of the social security disability program.



Dr. Hancock

Doctor Hancock has been chairman of the Committee since his original appointment in February, 1955. The citation lauded him for his "inspirational and dedicated leadership as Chairman of the Medical Advisory Committee, reflecting a keen sensitivity and responsiveness to the needs and interests of his profession and the public, and providing invaluable advice and guidance for the solution of the many complex problems encountered in assuring the successful launching of the administration of the disability provisions of the Social Security Act."

Past president of KSMA and the Southeastern Surgical Congress, and a professor of Clinical Surgery at the University of Louisville School of Medicine, he has received a number of other awards recognizing his contributions to the field of medicine. These awards include: The Woodstock Medal from the U of L; the E. M. Howard Medal from the KSMA; and the American Cancer Society Award for Distinguished Service.

U. of L. Medical School Planning Broad Curriculum Revision

The University of Louisville School of Medicine has been awarded $94,200 by The Commonwealth Fund of New York to assist it in a thoroughgoing study and revision of its curriculum.

Based on a report accepted in principle by the School's Medical Council in July of last year, the study will work out the specific details required to place the general recommendations of the report into effect, beginning with the freshman class of 1961. One more class will be placed under the new curriculum in each of the subsequent three years.

The report, prepared by a committee of the medical faculty under the chairmanship of Everett L. Pirkey, M.D., chairman of the Department of Radiology, focused its attention on the kind of medicine which will be practiced from 1970. Most students entering Medical School in 1961 will be entering practice almost 10 years later after graduation, internship, residency, and military service.

The report proposes broad principles to guide the curriculum revision. It believes that the curriculum should provide more instruction in the basic medical sciences, early contact with patients, knowledge of and skill in teaching, knowledge of and skill in research, and more free time and electives, providing greater flexibility with more individualized and self-reliant learning.

The committee which prepared the 1959 report will direct the curriculum revision through a staff headed by Doctor Pirkey and composed of two other professional persons. Each department will appoint a coordinator to help his department work out the necessary details.

The curriculum revision will not only improve instruction of students, but will supply a basis for planning a new instructional building for the Medical School, which the University hopes to undertake within a relatively short time.

Internists Elect Dr. McClendon, Install Dr. Fortune

Robert L. McClendon, M.D., Louisville, was named president-elect of the Kentucky Society of Internal Medicine at its annual meeting in Louisville on May 26. He will take office in June 1961.

Installed as president was Carl Fortune, M.D., Lexington, who succeeds George W. Pedigo, Jr., M.D., Louisville. Ralph Denham, M.D., Louisville, was re-elected secretary-treasurer.

Franklin B. Moosnick, M.D., Lexington, gave a report of the annual meeting of the American Society of Internal Medicine in San Francisco, which he attended as a delegate.

Medicare Claims Audited Recently to Check Physician Fees

O. Leon Higdon, M.D., chairman of the KSMA Committee on Federal Medical Services, has announced that the U. S. General Accounting Office has recently audited Medicare professional service claims paid to Kentucky physicians.

Following this audit, it reported that most of the physician claims were for the maximum fees allowable under the contract and that maybe Kentucky physicians were not fully aware that these allowable fees represented maxmium amounts.

Doctor Higdon noted that in accordance with the Prime Contract for Implementation of Public Law 569 (Medicare), the Medicare Manual and Schedule of Allowances reads, in part, as follows:

> "It is expected that **physicians** will **bill** the government their **normal charges** for persons with incomes of $4,500 **when** such charges are **less than** the stated **maximum allowances.**"

From the above, you can note that the government will pay the physician's usual charge or the amount provided for by the Medicare Schedule of Allowances, **whichever is less,** for authorized care under Medicare.

First Of Special PG Courses Set Oct. 12-13 In Bowling Green

A two-day postgraduate course on "Chronic Diseases" is scheduled for October 12 and 13 in Bowling Green—the first of a series of PG opportunities planned by the KSMA Committee on Postgraduate Medical Education for various locations in the state during the coming fall. Designed for general practitioners as well as specialists, the program will include a panel of noted physicians. Personal invitations and programs will be sent out.

The postgraduate course, "Symposium On Selected Topics On Gastro-Intestinal Diseases," held May 25-26 in Lexington, was attended by about 70 doctors from various parts of Kentucky.

Postgraduate listings through October in Kentucky and surrounding states have been announced by the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2. Detailed information on the meetings may be obtained by writing the office or calling JUniper 7-7135.

The complete listing to date follows:

July

18	Joint meeting of the Sixth Councilor District and the TB Hospital, Glasgow, with scientific-paper presentation for general practitioners; TB Hospital, Glasgow.
19	State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.
27-29	"Postgraduate Course in Tumors—Diagnosis and Treatment"; University of Tennessee College of Medicine, Memphis.

August

16	State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.
25	Joint meeting (tentative) of the First and Third Councilor Districts, with scientific-paper presentation.

September

7-10	Postgraduate Course in "Heart Disease—With Emphasis On Newer Diagnostic Techniques—Medical and Surgical Management"; Cardiac Laboratory, Cincinnati General Hospital; limited to 75 persons; fee, $75.
20-22	KSMA Annual Meeting, Columbia Auditorium, Louisville.
20	State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.
26-27	Tennessee Valley Medical Assembly, Read House, Chattanooga; For information, contact Dr. Robert A. Waters, 109 Medical Arts Building, Chattanooga, Tenn.

October

12-13	Tentative postgraduate course, "Chronic Diseases," with lectures, panel discussion and question period; sponsored by Kentucky State Department of Health, KSMA Postgraduate Medical Fund, U. of L. School of Medicine and U. of K. Medical Center; Ole Fort Restaurant, Bowling Green, Ky.; 2 p.m. Category I credit aplied for. No fees.
17-29	Postgraduate course, "Laryngology and Bronchoesophagology," sponsored by the University of Illinois College of Medicine, Department of Otolaryngology, under direction of Paul H. Holinger, M.D.; limited to 15 physicians. Register at the university, 1853 West Polk Street, Chicago 12, Ill.
18	State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.
19-20	Louisville Society of Internists, postgraduate meeting; Louisville.
20-22	Southern Medical Association, meeting; Hilton Hotel, El Paso, Texas.
27	Fifth Annual Fall Clinical Conference of the Lexington Clinic, Lexington.
29	Kentucky Chapter of the American College of Physicians, regional meeting; Lexington, Ky.

KSMA's First PG Medical Course Held In Lexington

The first postgraduate course sponsored by the KSMA's Postgraduate Medical Education Office and the KAGP was held May 25 and 26 at the University of Kentucky Medical Center in Lexington.

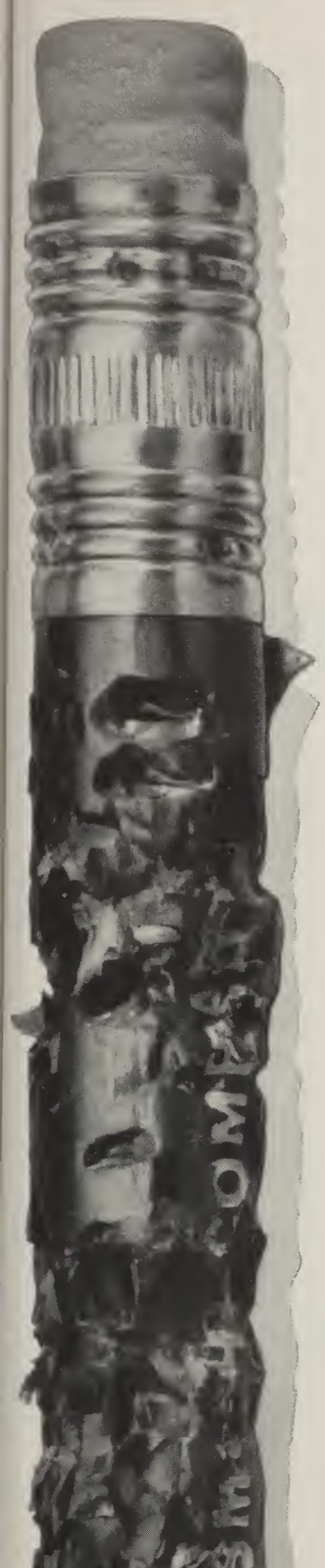
Sixty-five physicians were registered for the two-day session entitled, "Symposium on Selected Topics on Gastro-Intestinal Diseases." Physicians were welcomed to the conference by William R. Willard, M. D., Lexington, dean of the College of Medicine and vice-president of the Medical Center.

Included on the program were panel discussions and presentations by members of the staffs of the two medical schools. The program was approved for seven hours of category 1 credit by the American Academy of General Practice.

Dr. Glaboff Heads Pediatricians

J. J. Glaboff, M. D., Louisville, assistant professor of pediatrics at the University of Louisville School of Medicine, is the new president of the Kentucky Pediatric Society. Elected at the group's annual meeting in Somerset, he succeeds Robert N. McLeod, Jr., M. D., Somerset. He is a former president of the Louisville Pediatric Society.

Other officers named by the state society are: Vice-president, Murvel C. Blair, M. D., Frankfort, and secretary-treasurer, Edwin Paul Scott, M. D., Louisville.



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Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. *80*:481 (Oct.) 1958. 2. Ferrand, P. T.: Minnesota Med. *41*:853 (Dec.) 1958. 3. Mathews, F. P.: Am. J. Psychiat. *114*:1034 (May) 1958.

SEARLE

KSMA's Committees Active On Many Fronts

Committee to Study the Constitution and Bylaws

Cooley L. Combs, M.D., Chairman

Louisville **April 28, 1960**

The KSMA Committe to Study the Constitution and Bylaws at this meeting reviewed its activities and proposals to the 1959 House of Delegates. Minor changes for the Bylaws were considered and voted on as recommendations to the 1960 House of Delegates.

The Committee agreed upon the date and manner of submitting proposed constitutional changes to the county medical societies as provided by the Bylaws. The proposed change was given its first reading at the 1959 session.

Consideration was given to the proposed changes for streamlining the Association's committee structure and the Bylaws to implement these changes. Streamlining of the committee structure, however, depends upon the acceptance of the constitutional change by the House first. The Association's attorney participated in the discussion.

Associate Committee on Federal Medical Services

O. Leon Higdon, M.D., Chairman

Louisville **April 28, 1960**

After noting that there had been no complaints against the present contract and fee schedule, the Committee recommended to the KSMA Council that the Veterans Hometown Medical Care Program be renewed for another year.

The committee discussed the recommendation by the General Accounting Office that physicians doing work under the Medicare Contract should bill the government their normal charges for persons with incomes of $4,500, when such charges are less than the state maximum allowances. (See story on page 841)

Content of AMA resolutions 20 and 24, which call for a reduction and closer scrutiny on medical care of veterans in VA hospitals, was approved. The comimttee has asked the KSMA Council to prepare similar resolutions for presentation to the 1960 House of Delegates.

Legislative Committee

George Archer, M. D., Chr. National Affairs .

Louisville **April 28, 1960**

The Legislative Committee, at this meeting, used considerable time reviewing the activity of the 1960 session of the State Legislature. A report was given on the final action of a bill sponsored by KSMA, allied medical groups, public health and other organizations with bills having medical implications.

The Committee agreed that KSMA should back legislation in the 1962 Kentucky Legislature on compulsory immunization and also a bill to exempt from liability for civil damages any physician rendering medical care in emergency cases. Many suggestions were made for the 1962 session, such as clearing all bills with Allied Medical Council, State Department of Health, Attorney General's office and Governor's office, and giving more thought to bills that are to be introduced.

After a lengthy discussion on the aging problem at the national level, the Committee passed the following motion: "It is recommended by the Legislative Committee of the Kentucky State Medical Association that simple opposition to the current Forand bill will not serve the best interest of the people in the United States. As a result of our studies, we recommend that the Council consider possible means of cooperating in a proposed plan to budget the aged; such as the plan proposed by the Warren County Medical Association, the Javitts-Cooper bill, national Blue Cross plan, and the Kentucky Blue Cross-Blue Shield plan."

Committee on Medical Education and Economics

Gaithel L. Simpson, M.D., Chairman

Louisville **April 28, 1960**

The KSMA Committe on Medical Education and Economics discussed the Indigent Care Bill that was enacted by the 1960 General Assembly. Members expressed a wish that all physicians take an interest in the plan and diligently see that it is not abused.

A proposal that all physicians be required to practice as GP's for a period of years before going into specialty fields was felt not to be feasible. It was thought that the suggestion did have merit and would be good for the physician but would be difficult to control by compulsion.

Also, the committee asked the KSMA Council to keep the idea of a Relative Value Study in Kentucky alive and to continue to investigate its merits.

KSMA Liaison Committee to Voluntary Health Groups

Ralph Denham, M.D., Chairman

Louisville **May 5, 1960**

In compliance with the request of the 1959 House of Delegates, the KSMA Liaison Committee to Voluntary Health Groups formulated plans at this its first meeting to contact various voluntary health organizations.

It was decided that the committee would send letters to these groups offering its assistance. All groups were also to be sent a copy of "Mutual Obligations Between Medical Societies and Voluntary Health Agencies."

(More Reports on Page 846)



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Committee Reports

KSMA Advisory Commission to Blue Shield

W. Vinson Pierce, M. D., Chairman

Louisville **May 12, 1960**

The first meeting of the Commission this year reviewed the results of recommendations made to the Board of Directors of the Physicians Mutual and to the House of Delegates of KSMA. These included a proposal for special old age coverage, new procedures for the payment of services rendered by dentists and efforts to obtain information regarded as valuable in establishing proper allowances.

There was a lengthy discussion covering misunderstanding and unnecessary utilization of coverage offered by the Kentucky Physicians Mutual, the Blue Shield Plan for Kentucky.

After hearing recommendations for changing the allowances from certain special groups, the Commission adopted a motion recommending to the Board of Directors of Physicians Mutual that an overall study be made of the schedule of allowances with a view to correcting existing inequities. The Commission set July 21 as its next meeting date.

KSMA Associate Committee on Aging

Earl P. Oliver, M.D., Chairman

Louisville **May 19, 1960**

Joe Miller, AMA field representative, reported briefly on the status in Congress of the proposed health care plan for the aged. He noted that the situation was now developing more along political lines.

The committee also discussed the forthcoming state Conference sponsored by the Citizens Commission on Aging that will be held September 1-2, and the White House Conference on Aging scheduled for January 9-12, 1961.

In carrying out a recommendation of the House of Delegates, the committee voted to again contact all county societies and urge them to actively consider the problem of adequate medical care for the aged.

The committee was unanimous in its feeling that the medical profession should emphasize a positive program for the aged, pointing out the individual's personal stake and responsibility in taking care of himself. By getting this down to a matter of dollars and cents, the committee feels we can get more citizens to see what their stake is in medical care in the future.

Committee to Study New Home

George F. Brockman, M. D., Chairman

Louisville **May 25, 1960**

The Committee to Study the New Home for the KSMA Headquarters Office met in the Saddle Room at the Brown Hotel, Louisville, on Wednesday, May 25.

The Committee reviewed the mandate of the 1959 House of Delegates relative to its task of looking into the situation and making recommendations as to the possible benefits of a new home for the Headquarters Office.

Tentative recommendations as to the type of location, method of financing, architectural aspects and city of location were considered.

It was decided that the Committee should have at least one more meeting prior to making its recommendations to the House of Delegates.

Physicians Placement Committee

Delmas M. Clardy, M. D., Chairman

Lexington **May 26, 1960**

The Physicians Placement Committee met at the Campbell House in Lexington on May 26. Committee actions centered around the purposes for its existence—broadening KSMA services generally, helping communities to procure physicians and physicians to get associates, and assisting physicians in search of needy and desirable locations.

Much emphasis was placed on the need of KSMA Placement Service keeping in closer contact with Kentucky medical students, both in and out of Kentucky. It was pointed out that valuable assistance, financially and educationally, could be rendered externs by helping them obtain summer employment in doctors' offices and hospitals.

With the proper follow-up, the Committee felt, a greater number of native Kentucky senior medical students and interns would decide to locate in the state. The same would be true of doctors taking residency training, if desirable needy locations and openings for associates were called to their attention.

Committee on Public Information and Service

N. L. Bosworth, M.D., Chairman

Lexington **June 9, 1960**

The Committee on Public Information and Service in its second meeting of the Associational year initiated plans for holding the second annual luncheon in honor of new members coming into the Association since September 1, 1959. The luncheon will be held in conjunction with the 1960 Annual Meeting on Tuesday, September 20, at the Brown Hotel, Louisville.

In addition to considering some specific requests from the KSMA Council, the Committee further discussed the 1960 Senior Day and made some recommendations for the Senior Day program in 1961.

Also, the Committee recommended to the KSMA Council that an exhibit, "Medicine As a Career," be purchased from the AMA and kept in the KSMA Headquarters Office. This exhibit would be available for loan to county societies in the promotion of Health Career Days.

Dr. Cartmell Renamed to Board

William H. Cartmell, M.D., Maysville, has been reappointed by Governor Combs to a four-year term as a member of the board of regents at Morehead College, beginning April 1. The board renamed him vice-chairman.

Dr. Brown Appointed Director of State Lab in Frankfort

B. F. Brown, M.D., director of the Owensboro-Daviess County Health Department, has been named to direct the new State Health Department laboratories in Frankfort, according to Russell Teague, M.D., State health commissioner. He assumed the title of acting director of the labs on July 1.

Since State law requires the laboratory director to have training beyond the M. D. degree, he will attend the University of North Carolina for a year, starting in September, to study for a master-of-public-health degree. He will also take advanced training at other public health centers.

Doctor Brown will be the first M.D. to head the laboratory division since the retirement of L. H. South, M.D., several years ago.

In making the announcement, Doctor Teague also stated that a regional laboratory of the State Health Department will not remain in Louisville as had been planned. Some equipment and personnel of the present State lab may be transferred to the Louisville-Jefferson County Health Department, however, and it may get further financial aid from the State.

Health Board Takes State Offer

The State's offer to take a large number of Waverly Hills Tuberculosis Sanatorium patients by July 1 has been accepted by members of the Louisville-Jefferson County Health Board, according to Gradie R. Rowntree, M. D., Louisville, Board chairman.

The commission offered on May 6 to take up half of Waverly Hills' patients and treat them at Hazlewood State Tuberculosis Hospital here. Waverly Hills has about 270 patients. The rest of Waverly Hills patients would be transferred to Hazlewood, and Waverly closed down, when a Hazelwood renovation program is completed in the summer of 1961. Full details were to be worked out with the State Tuberculosis Commission.

Direct Distance Dialing Comes To Louisville Aug. 7

Beginning August 7, physicians of the Louisville area will be able to make long distance telephone calls to certain cities of the United States and Canada by direct dialing. Owensboro, Frankfort and Carrollton will also get the new service on that date, followed by Harrodsburg and Danville in September.

The new method of handling long distance calls is already in operation in a number of Kentucky cities. Winchester was first, then Madisonville and Shelbyville. Paducah, Murray, Mayfield, Marion and Gilbertsville were added to the network on May 15.

Under the new system, the entire country is divided into areas with codes. Each area serves all or part of a state and has its three-digit number. To place a call, a customer need only dial the figure "1" followed by the area code and then the telephone number in the distant city. For instance, to call someone in Chicago at DEarborn 2-9959, the customer would dial "1" to connect to the long distance equipment, 212 to get into the proper area, and DE 2-9959 to reach the customer.

Kentucky has two area code numbers—502 for the western part and 606 for the eastern part. In any calling area no two telephone numbers are duplicated. If, for instance, a Paducah customer wanted to call a Louisville number it would not be necessary to dial the area code since both are in the 502 area.

The new service is limited to station-to-station calling.

U of L Receives Heart Grants Amounting to $17,600

Three research grants amounting to $17,600 were recently awarded to University of Louisville Medical School faculty members by the American Heart Association. The grants, among 216 awarded throughout the nation, were effective July 1.

Beverly T. Towery, M. D., chairman of the department of medicine, received a $6,600 grant for research by William A. Brodsky, M. D., professor of experimental medicine, on the use of salts by the body.

Grants of $5,500 each were awarded to Robert S. Levy, Ph. D., department of biochemistry, and Sheppard M. Walker, Ph. D., department of physiology. Doctor Levy will study how chemicals in the body act to split up fatty substances in the blood. Doctor Walker's grant is for the study of the contractions of the heart muscle.

The Kentucky Heart Association which joined in announcing the grants noted that $37,820 in AHA awards to physicians was reported in February, and the new grants bring the year's total to $55,420.

U of L Raises Its Tuition

A recent announcement of tuition increases at the University of Louisville means that medical students will have to pay $1,025 a year—if they live inside Kentucky's borders. Non-Kentuckians will pay $1,525. This is a raise of $125 and $225, respectively.

The raises also affect students in other colleges of the university. In all other parts of the university residency is based on city limits—rather than state boundaries. Biggest part of the money by far will go into "long-overdue" salary increases for the faculty, according to U of L President Philip Davidson.

Dr. Christophersen Gives Talks In Europe During June

William M. Christophersen, M. D., chairman of the pathology department at the University of Louisville Medical School, gave three lectures at meetings in Europe during June.

On June 15 he addressed the fourth International Congress of Clinical Pathology in Madrid on results of screening tests in the Louisville Cytological Laboratory.

He gave another talk on cancer-research projects before the International Academy of Pathology on June 20 in London.

NEWS ITEMS

William B. Atkinson, M.D., professor of anatomy at the University of Louisville School of Medicine, has received his third three-year appointment as scientific associate of the Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine. He will do research on adrenal cancer in mice during the summers and continue to teach at the Medical School. Assisting him in the research project as visiting investigators will be two other Medical School professors, **Richard H. Swigart, M.D.,** and **Frederick K. Hilton, M.D.** Doctor Atkinson is scheduled to fly to Copenhagen, Denmark, July 16 to present a paper to the First International Congress of Endocrinology on special pregnancy problems among diabetic women, and to go to Paris in August to address the First International Congress of Histochemistry and Cytochemistry on studying enzymes in human tissue.

Leonard C. Brown, M.D., has joined the Henderson County Health Department after practicing medicine in Floyd county for 27 months. Doctor Brown, a native of Iowa City, Iowa, received his medical degree from Northwestern University in 1954 and interned at Chicago's Wesley Memorial Hospital. He was a lieutenant in the U. S. Navy from 1957-58.

James W. Bryan, M.D., Louisville, was recently honored by being named "Downtown Optimist Man of the Year" for his "outstanding service to the youth of Kentucky." A member of the Downtown Optimist Club since 1939, he was president in 1957-8, is a past lieutenant governor of the Third District of Optimist International, and is currently chairman of the district's committee on boys' work.

A. D. Butterworth, M.D., Murray, has retired from active practice and has accepted the post of Health Officer of Calloway county. He succeeds **Norman A. Parrott, M.D.,** who resigned to enter private practice in Paducah. The area that Doctor Butterworth will serve also includes Marshall, Lyon and Livingston counties.

J. C. Hart, M. D., has retired from practice after 40 years as a Paris physician. He plans to move with his wife to Silver Springs, Fla., where he has purchased a motel.

The family of **Paul F. Maddox, M. D.,** Campton, has been selected to represent the Wolfe County Woman's Club in an All-American Family search conducted by the Book of Knowledge in cooperation with General Federation of Women's Clubs. Doctor and Mrs. Maddox, who own and operate Maddox Clinic in Campton, are both active in civic affairs. A 1952 graduate of the University of Louisville School of Medicine, Doctor Maddox is a teacher in the Methodist Sunday School, a trustee of the Town Council, an officer in the Kiwanis Club, a director of the fair board and chairman of the sociological committee of the Wolfe County Rural Development Program. Mrs. Wolfe, also a Sunday school teacher, is an active member of the Wolfe County Woman's Club and the Campton Parent-Teacher Association. They are the parents of four young sons ranging in age from 3 months to 7 years.

C. J. McGruder, Jr., M.D. is a new member of the staff of the Henderson Clinic, Henderson, specializing in obstetrics and gynecology. He practiced in Bellingham, Wash., from July 1956 to May 1960. Born in Hopkinsville, Doctor McGruder received his M. D., degree from the University of Tennessee in 1951. He interned at John Gaston Hospital, Memphis, and was resident at Louisville General Hospital from 1955 to 1958. He served in the U. S. Air Force from 1952 to 1954, attaining the rank of captain.

Sheldon Kessler, M. D., has joined the staff of the Henderson Clinic, Henderson, after practicing in Mount Vernon, N. Y., since 1956. His specialty is pediatrics. A native of Brooklyn, N. Y., Doctor Kessler received his medical degree from St. Louis University in 1951 and interned at Metropolitan Hospital, New York, where he also spent a year's residency. He served as a first lieutenant in the U.S. Army from 1953-55, after which he was a resident in Texas Children's Hospital, Houston, for a year.

Malcolm H. King, M. D., has discontinued his practice in Paris to study in Cleveland for two years. He will specialize in anesthesia. While in Paris, Doctor King was associated with William Cox, M. D.

Eli J. George, M. D., Lebanon, has announced that his nephew **Salem M. George, M. D.,** has become associated with him in general practice. A graduate of the University of Louisville Medical School in 1959, Doctor George interned at St. Joseph Infirmary, Louisville.

Myron J. Szczukowski, M.D., radiologist, has started practice in Owensboro in association with John L. Dixon, M.D., and Frank H. Wight, Jr., M.D. He came to Kentucky from Ancon, Canal Zone, where he was chief of radiology service at Gorgas Hospital from January 1958 to March 1960. Born in Alpena, Mich., Doctor Szczukowski received his M.D. degree from St. Louis University School of Medicine in 1949. He interned at Gorgas Hospital and took his residency training at the University of Colorado and V. A. Hospital, Denver, from 1955-57. He served as a major in the U. S. Air Force for six years: 1943-45, 1949-50 and 1953-55.

Emmett Whitford Wood, M.D., has started the practice of medicine in Bardstown after completing his internship at Methodist Hospital, Memphis, Tenn. A native of Water Valley, Miss., Doctor Wood was graduated from the University of Tennessee College of Medicine in 1959. He served in the U.S. Navy from 1942-46.

County Society Reports

Harlan

Featured speaker at the May meeting of the Harlan County Medical Society was Robert S. Myers, M. D., executive assistant director of the American College of Surgeons who spoke on "The Medical Profession—Its Past, Present and Future."

Doctor Myer's talk dealt with the roles of the general practitioner and surgeon in a community hospital. Guests of honor at the meeting were Keith P. Smith, M. D., Corbin, 15th District Councilor; and Willard Buttermore, M. D., Corbin, a member of the KSMA legislative committee.

Two potential premedical student guests also attended. Other potential premedical students are to be guests at other meetings according to William H. Anderson, M. D., Harlan, secretary, who called it "an effort to encourage more of our brighter youngsters to accept medicine as a career."

McCracken County

The McCracken County Medical Society approved proposed changes in its Constitution and Bylaws at the regular meeting on May 25.

The application of Ben Bradford, M. D., for transfer of membership from the Massac County Medical Society to the McCracken Society was accepted.

In a discussion relative to listings in the new Telephone Directory, members were reminded of the society's former action regarding one listing in the yellow pages of the directory.

The scientific program was presented by Lawrence G. Schull, M. D., professor of anesthesiology at Vanderbilt University. His subject was "Anesthesia Problems."

Geriatrics Society Elects Wallace

Ira O. Wallace, administrator of the New Castle Sanitarnum, New Castle, was elected president of the National Geriatrics Society at its annual convention in Miami Beach in May.

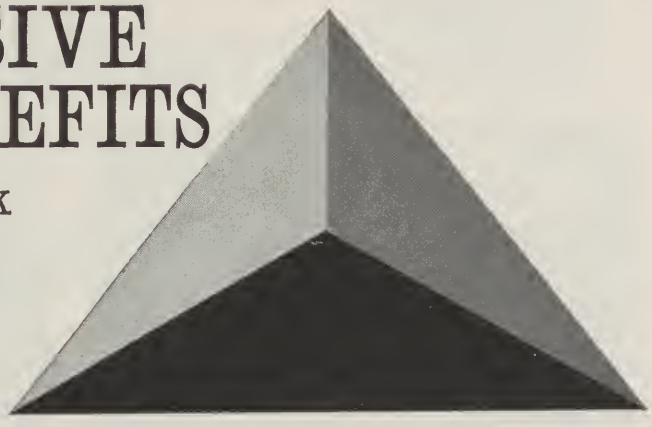
Mr. Wallace is past president of the Kentucky Geriatric Society and has served as an advisor to the federal government on the problems of the aged. He is also past president of the National Association of Nursing Homes and the Kentucky Association of Nursing Homes.

Dr. Githens UK Pediatric Head

John H. Githens, M. D., who is now with the University of Colorado Medical School, was recently appointed chairman of the pediatrics department in the School of Medicine of the University of Kentucky by the University's Board of Trustees. At the same meeting, the trustees appointed Robert L. Johnson, executive director of the Medical Foundation, Inc., Boston, as community-services director for the U of K Medical Center.

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In Memoriam

FLOYD GILBERT ESTRIDGE, M.D.
Lancaster
1907 - 1960

Floyd G. Estridge, M.D., native of Berea and practicing physician and surgeon in Lancaster since 1947, died on April 30 at Pattie A. Clay Infirmary, Richmond, after a short illness.

A graduate of the University of Tennessee Medical School, he was the recipient of a scholarship from the State of Kentucky for study at Johns Hopkins. He served his internship at Meriden, Connecticut, City Hospital, and was senior medical officer for the TVA. From 1944 to 1947 he practiced in Chattanooga.

W. P. SIGHTS, M.D.
Paducah
1887 - 1960

Warren P. Sights, M. D., died at his home in Paducah on May 19. He had been in ill health for about two years.

Doctor Sights started practicing in Paducah in 1920. He graduated from Rush Medical School, Chicago, in 1915. During World War I he was a captain in the medical corps, serving in France. A native of Corydon, he went to Paducah in 1898.

50 Attend 7th Dist. Meeting

Fifty physicians attended the meeting of the Seventh Councilor District at the Frankfort Country Club on May 19, according to Wyatt Norvell, M. D., New Castle, district councilor.

Hugh C. Williams, M. D., Carrollton, district president, presided at the meeting which featured a talk by Irvin Abell, M. D., Louisville, KSMA president; and four scientific presentations. Scientific speakers included: William A. Blodgett, M. D., Louisville; Shelby Hicks, M. D., New Castle; Morris M. Weiss, M. D., Louisville; and William E. Pugh, M. D., Louisville. Host group was the Franklin County Medical Society of which Joseph H. Liebman, M. D., Frankfort, is secretary.

2nd Dist. Meets in Owensboro

"The Political Climate for American Medicine" was discussed by KSMA President Irvin Abell, Jr., M. D., Louisville, at a meeting of the Second Councilor District in Owensboro, May 31.

Forty-five physicians attended the meeting, according to Walter L. O' Nan, M. D., Henderson, district councilor. Scientific presentation at the meeting was made by Rudolf J. Noer, M. D., of the University of Louisville. Host group was the Daviess County Medical Society of which Jack Blackstone, M. D., Owensboro, is president.

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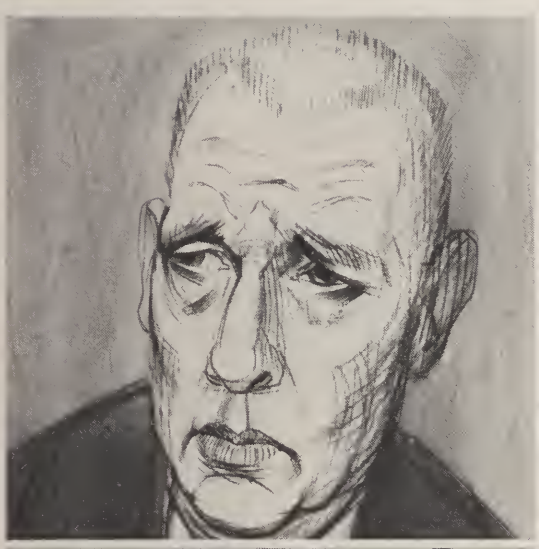
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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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WASHINGTON NEWS DIGEST

(Continued from Page 786)

major efforts to trying to get the Senate to substitute the Social Security approach.

The committee had been considering health-care-for-the-aged legislation intermittently for more than a year. Hearings were held on the Forand bill last summer but action was postponed until this year.

Prior to approving the Mills plan, the committee rejected the Forand bill (three times) and the Eisenhower Administration's far-reaching public assistance alternative. Both plans were opposed by the medical profession and allied groups.

While these legislative proposals were in the limelight, a little-noticed bill was enacted into law to give $50 million in relief to taxpayers burdened with taking care of ill dependent parents.

The new law permits taxpayers full deduction on Federal income taxes for medical and dental expenses paid for a dependent parent 65 years of age and older. Previously, such a deduction was limited to costs in excess of three per cent of the taxpayer's adjusted gross income.

Three Social Security Changes

Changes in the Social Security program called for in the catch-all bill approved by the Ways and Means Committee included:

(1) Eliminate the requirement that a disabled person must be a least 50 years old to be eligible for Social Security benefits.

(2) Provide Social Security benefits for about 25,000 widows of workers who died before 1940.

(3) Increase the benefits of 400,000 surviving children of workers covered by Social Security.

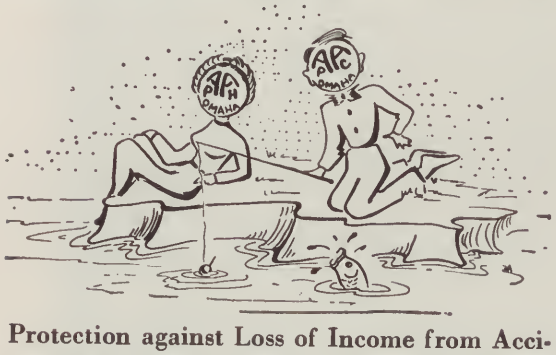
Although all these revisions will increase costs of the program, neither the Social Security tax rate nor tax base was increased.

The revisions will mark the fifth consecutive year of a national election that the Social Security program, originally enacted in 1935, has been expanded. Some of the expansions have been accompanied by tax increases.

U of K Honors Mrs. Van Meter

Mrs. Harriet Drury VanMeter, wife of J. Farra VanMeter, M. D., Lexington, was awarded the Sullivan Medallion by the University of Kentucky at its 93rd annual commencement exercises in May. The medallion is given annually to an outstanding Kentucky citizen.

In making the presentation, Dr. Frank Dickey, U. K. president, noted Mrs. VanMeter's service to students from foreign lands. She is acting director of Sayre School, chairman of the Board of the Manchester Center, a board member of the Blue Grass Center for the Mentally Retarded, and the Junior League's Council for Social Planning. A U. of K. graduate, she is past president of the Travelers Aid Society and of the Girl Scout Council in Lexington.



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IN THE BOOKS

TEXTBOOK OF OTOLARYNGOLOGY: by David D. DeWeese, M.D., and William H. Saunders, M.D.; published by the C. V. Mosby Company, St. Louis, Mo.; 1960; 464 pages; price, $8.75.

The textbook of Otolaryngology by Deweese and Saunders is exactly what is says it is in preface: "Designed primarily for the medical student and general practitioner. Emphasis is on diagnosis and treatment."

The chapters on the physical examination are very thorough and complete. Indications and techniques for a tonsillectomy and adenoidectomy, for instance, are covered very thoroughly. But indications for and techniques of such complex procedures as a rhinoplasty and laryngectomy are discussed fairly superficially. Such things that are likely to be treated by a general practitioner, as nose bleeds, are given a full chapter, Also office audiometry and other methods of hearing testing are quite fully discussed.

For what it seeks to do it is an excellent book. It will not be sufficient, however, for the Otolaryngologist.

William C. Wolfe, M. D.

SMOKING AND HEALTH: by Albert Ochsner, M.D.; published by Julian Messner, Inc., New York; 1960; 108 pages; price, $3.

Dr. Ochsner, in his earlier work, confined his remarks to smoking and cancer of the lung. The present volume covers the whole field of health as affected by smoking, with its major emphasis on endobronchial carcinoma. It is primarily a book for the layman. but may be read with profit by the profession.

It contains much factual, up-to-date data and numerous illuminating graphs. There is a good bibliography for those who may wish to read the original articles. In the present volume, he pulls out all the stops and runs the whole gamut of the health field —lungs, heart, digestion and sex. The book is concise. Doctor Ochsner's pungent wit breaks through in every chapter, which makes for delightful reading.

The author is forthright in his belief that "cigarettes cause cancer," and puts forth incontestable proof and cogent arguments in support of his thesis. The chapter on the deleterious effects of nicotine on the cardiovascular system is well documented. Obstetricians and gynecologist will find the chapter on "Smoking and Sex" interesting reading, but perhaps somewhat debatable, such as "A German study of more than 5,000 women indicates there is a greater incidence of frigidity, sterility, and menstrual disturbances, and miscarriages, among women smokers than among nonsmokers."

In another paragraph he quotes the following: "Many physicians now agree that the decreased sexual activity of men in their thirties and forties can often be traced to excessive smoking."

A perusal of Doctor Ochsner's book will leave no doubt in one's mind of the injurious effects of heavy cigarette smoking (a package or more a day) on the general health of the average individual.

Oscar O. Miller, M.D., F.A.C.P.

New Books

Following is a list of books received by the Association for review. Those considered of particular interest to Journal readers will be reviewed as space permits. All complimentary copies of books received are turned over to the University of Louisville-Jefferson County Medical Society Library. Inquiries concerning a particular book should be made to the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky.

COMMUNICABLE AND INFECTIOUS DISEASES: by Franklin H. Top, M.D.; published by the C. V. Mosby Company, St. Louis.

MEDICAL CARE OF THE ADOLESCENT: by J. Roswell Gallagher, M.D.; published by Appleton-Century-Crofts, Inc., New York.

ANATOMY: by Ernest Gardner, M.D.; Donald J. Gray, Ph.D., and Ronan O'Rahilly, M.Sc., M.D.; published by W. B. Saunders Company, Philadelphia and London.

A TRAVELER'S GUIDE TO GOOD HEALTH: by Colter Rule, M.D.; published by Doubleday & Company, Inc., Garden City, N. Y.

PRINCIPLES OF PUBLIC HEALTH ADMINISTRATION: by John J. Hanlon, M.S., M.D., M.P.H.; published by the C. V. Mosby Company, St. Louis.

EDEMA—MECHANISMS AND MANAGEMENT: by John H. Moyer, M.D., and Morton Fuchs, M.D.; published by W. B. Saunders Company, Philadelphia and London.

MEDICAL, SURGICAL AND GYNECOLOGICAL COMPLICATIONS OF PREGNANCY: edited by Alan F. Guttmacher, M.D., and Joseph J. Rovinsky, M.D.; published by the Williams & Wilkins Company, Baltimore, Md.

FUNDAMENTALS OF CLINICAL HEMATOLOGY: by Byrd S. Leavell, M.D., and Oscar A. Thorup, Jr., M.D.; published by W. B. Saunders Company, Philadelphia and London.

CLINICAL OBSTETRICS AND GYNECOLOGY: edited by John W. Huffman, M.D., and Martin L. Stone, M.D.; published by Paul B. Hoeber, Inc., New York.

THE LIST METHOD OF PSYCHOTHERAPY: by Elizabeth Sher, et al; published by Philosophical Library, Inc.

WOMEN AND FATIGUE: by Marion Hilliard, M.D.; published by Doubleday & Co., Inc., Garden City, N. Y.

NINE MONTHS' READING: by Robert E. Hall, M.D.; published by Doubleday & Co., Inc., Garden City, N. Y.

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PERTINENT PARAGRAPHS

The Third International Congress of Physical Medicine will be held August 21-26 at The Mayflower in Washington, D. C., according to Walter J. Zeiter, M.D., secretary general. Also announced by Doctor Zeiter are the Seventh Annual Essay Award and the Third Bernard M. Baruch Essay Award, sponsored by the American Congress of Physical Medicine and Rehabilitation, and the R. D. Grant Company Award for the best paper on "Etiology of Decubitis Ulcers." Manuscripts for the two ACPMR awards may be on any subject of interest or pertaining to the field of physical medicine and rehabilitation. More information may be obtained by writing the American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Ill.

The Department of Otolaryngology, University of Illinois College of Medicine, has announced a postgraduate course in laryngology and bronchoesophagology to be conducted October 17-29, under the direction of Paul H. Holinger, M.D., Registration will be limited to 15 physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures. For further information, write directly to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12.

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PUBLIC HEALTH PAGE

New Developments In Public Health

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health Commonwealth of Kentucky*

Expansion of County Health Services

THE 1960 General Assembly passed 20 bills dealing directly with, or relating to, public health. One immediate effect of the new legislation is to bring greatly needed improvements to community health services. Increased appropriations of $1,465,450 for the next two-year period will further implement the Public Health Foundation Program. Many more county health departments will now have health officers and others such as nurses, sanitarians, health educators and nutritionists on their staffs.

Expanded staffs and facilities mean more services to infants and children, improved control of communicable disease, and help with sanitation and other local community health projects. More county health departments can offer services for the aging and chronically ill, such as the nationally recognized home-care program already successfully demonstrated in several counties.

Medical Care for the Indigent

The Governor's Reorganization Bill contains the heart of the indigent medical care proposal of two years ago. A Division of Medical Care within the State Department of Health will carry out medical aspects of the program, while the Department of Economic Security is responsible for certifying eligibility of recipients and for general and fiscal administration. Funds available in state and federal appropriations amount to around $4,500,000, to finance the program for the 18-month period from January 1961 through June 1962.

The bill creates an Advisory Council for Medical Assistance, to be appointed by the Governor. It further authorizes the Commissioner of Health to appoint in each county a medical review committee of three physicians and one dentist.

Laboratory Services and Research

An additional appropriation of $151,486 for the biennium will make possible expanded laboratory services and research programs. Limitations of staff and facilities in the past have restricted both research activities and services in the Health Department's laboratories. Kentucky physicians and allied professional workers will directly benefit from the new facilities soon to be in operation.

Behavioral Sciences

Increased funds for general operations at the state level will enable the State Health Department to initiate, among its new programs, a Division of Behavioral Sciences, with $56,900 for the biennium. Findings in behaviorial patterns of population groups will provide information essential to understanding basic causes and human factors involved in public health. Research in these sciences contributes significantly to planning new methods and approaches in helping people solve many of their community health problems.

Radiological Health

With the advent of nuclear power, a sleeping giant has been awakened to confront public-health workers with the numerous complexities involved in radiological health. Long overdue for attention are the less spectacular but no less important small sources of ionizing radiation. With a new Radiological Health Division in the State Health Department, made possible by $53,219 of the expansion funds, Kentucky's public health efforts will enter into a new scientific age where progress is mandatory. The potential of radiation to impair health and to alter the basic characteristics of the species can no longer be ignored.

Tuberculosis Control

Improved control of tuberculosis will be aided during the biennium with increased financial support by a total of $31,214 of state funds. Kentucky is still faced with 6,764 known active cases of tuberculosis. Empty beds in tuberculosis hospitals indicate that facilities are not fully utilized to cope with this major health problem. The additional funds will help county health departments in case-finding and hospital referrals, will supply anti-tuberculosis drugs to medically indigent patients after release from hospitals, and thereby will materially assist the tuberculosis hospital program.

(Continued on Next Page)

PUBLIC HEALTH PAGE

(Continued)

Occupational Health and Air Pollution

Approximately $80,000 will be available to expand the present limited program dealing with occupational health hazards and the rapidly growing problems of air pollution. The critical consequences of uncontrolled pollution of the atmosphere affect city planners and industrialists as well as medical specialists. Air pollution means economic loss added to health injury, whether acute disaster strikes or insidious damage is spread day by day. New public health programs made possible by increased funds will help alleviate the problems arising from industrial use of chemicals and other sources of pollution.

Water Supply Safety

Greatly increased demands for skilled engineering services have pointed to the need for more engineers to advise on construction and inspect water-treatment plants, swimming pools, sewage disposal plants, and to advise and train water plant operators. Shortage of personnel has meant that State Health Department engineers have inspected fewer than 30 per cent of the swimming pools in the state and have not been able to inspect all water plants even once a year. Funds amounting to $64,851 are available during the biennium to employ more engineers to insure improved water supplies and the control of water pollution.

An Investment in the Future

Public health programs are vital to the health and the economy of the people of Kentucky. Without funds available from the Governor's new revenue program, many public health needs would go unmet. The increase in funds for expanding present programs and initiating new services will bring great returns in improved health and well-being of Kentuckians.

KAGP Seminar Attended by 80

More than 80 physicians and their wives attended the KAGP Harrodsburg Seminar at the Beaumont Inn in Harrodsburg on June 2, according to Paul Sides, M. D., Lancaster, general chairman.

The program, which was acceptable for 5 hours of category 1 credit by the AAGP, included scientific presentations by five Kentucky physicians. Speakers included: Joseph Little, M. D., Louisivlle; Robert Lich, M.D., Louisville; Ullin Leavell, Jr., M. D., Lexington; George Greene, M. D., Lexington; and Alfred O. Miller, M. D., Louisville.

The 1960 Annual Meeting of the American Heart Association will be held in St. Louis, October 21-25. The Association's scientific sessions are scheduled from Friday, October 21 through Sunday, October 23 in Kiel Auditorium.

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STUDY OF MATERNAL MORTALITY



THIS patient was a 46-year-old white married gravida 9, para 8. She consulted her private physician in the fifth month of pregnancy. Her last menstrual period began on August 10, so that the expected date of delivery was May 17, 1959. There was no history of any previous medical, surgical or obstetrical abnormalities.

The only detected complication of pregnancy was the elevation of her blood pressure when she was last seen in ninth month of gestation.

Labor apparently began spontaneously on May 16, 1959. Forty-five minutes after she was admitted she vomited, had a convulsion, and became semi-comatose. The blood pressure was not recorded. Her respiration became depressed and she exhibited cyanosis and rapid, thready pulse. Digitalis and oxygen were administered.

A stillborn female weighing 7 pounds 2 ounces was delivered by high forceps after the cervix had been manually dilated. The placenta was delivered intact. Following delivery, sodium amytal was given intravenously.

Thirty minutes after delivery the patient began to react, complaining of a severe headache and appearing very restless. Fifteen minutes later, the blood pressure fell to 50/20. Nasal oxygen was given continuously, and glucose was injected intravenously. She vomited frequently, had to be continuously suctioned.

Fifty minutes to one hour after delivery she began to bleed profusely from the vagina, after other hemostatic measures had failed, a pack was inserted into the uterus. The bleeding continued, although it was less profuse after insertion of the pack. Catheterization produced grossly bloody urine. In spite of continued intensive therapy, the patient's condition continued to deteriorate, and she died at 4 a.m. on May 16, 1959. No autopsy was performed. The cause of death stated on the certificate was cerebrovascular accident due to hypertension due to acute nephritis.

Comment

The Committee considered this case to be an example of direct obstetrical death for which the physician was responsible. The patient's diastolic blood pressure had been normal at her initial visit, but at the last prenatal visit both systolic and diastolic readings were elevated. Nevertheless, no specific treatment was undertaken. The information provided failed to specify the amount of cervical dilatation before the dilatation was completed manually and high forcepts delivery was performed.

This type of delivery cannot any longer be considered acceptable obstetric practice, for reasons illustrated by the case in point, with its fatal outcome for both mother and child. It is unclear from the protocol why the sudden postpartum vaginal hemorrhage should have taken place, and why adequate hemostasis was never attained. Packing of the uterus was finally undertaken, only to have the bleeding continue. More vigorous and definitive hemostatic measures should have been undertaken promptly.

Although the patient's age and hypertensive status are compatible with the possibility of a cerebrovascular accident, in the absence of autopsy confirmation of such a diagnosis, the most probable cause of death in this patient was a ruptured uterus secondary to the unjustifiably traumatic delivery.

Prenatal Record

	1	2	3	4	5	6	7	8			9
								1	2	3	4
Blood Pressure					160/80				170/100		
Weight					165				188		
Urine					neg.				neg.		
Rh											
Serology					neg.						

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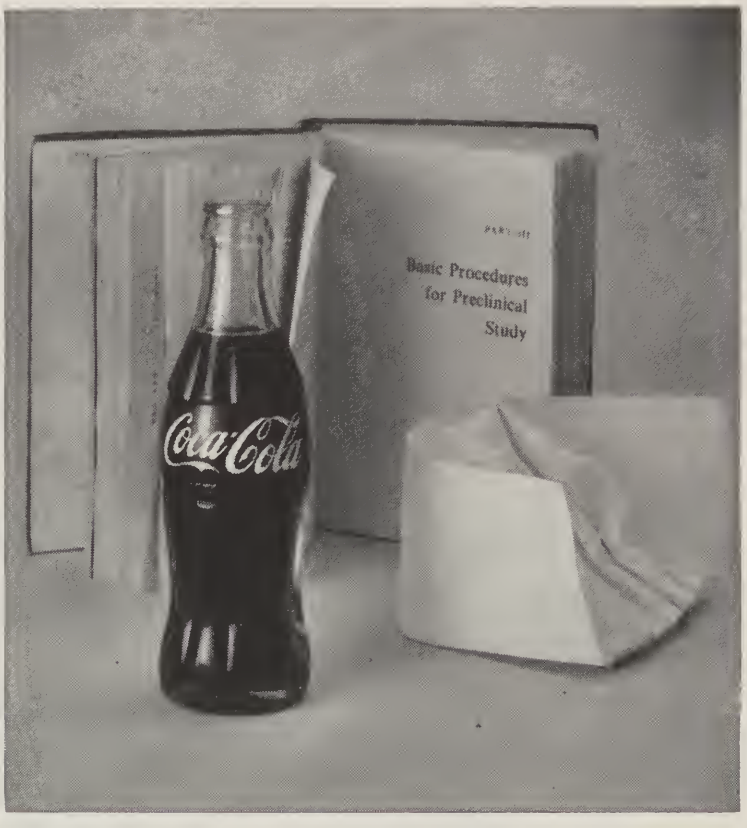


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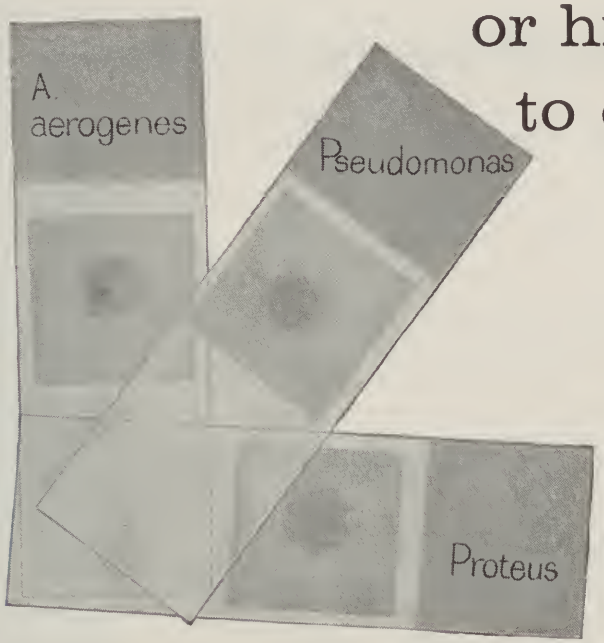
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1. Projection from Vital Statistics, U.S. Government Dept. HEW, Vol. 48, No. 14, 1958, p. 398.
2. Modell, W.: Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.

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References: 1. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 2. Lichtman, A. L.: Scientific Exhibit, Internat. Coll. Surgeons, Miami Beach, Fla., Jan. 4-7, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April. 1960.

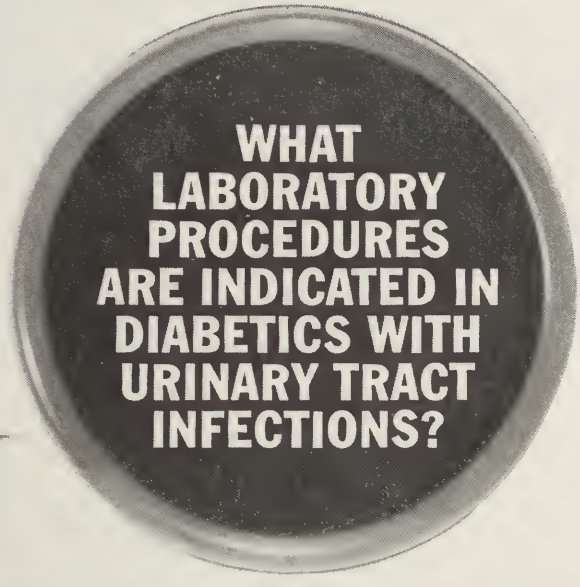
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1. Goddard, E.S.: in *Trifluoperazine, Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959.

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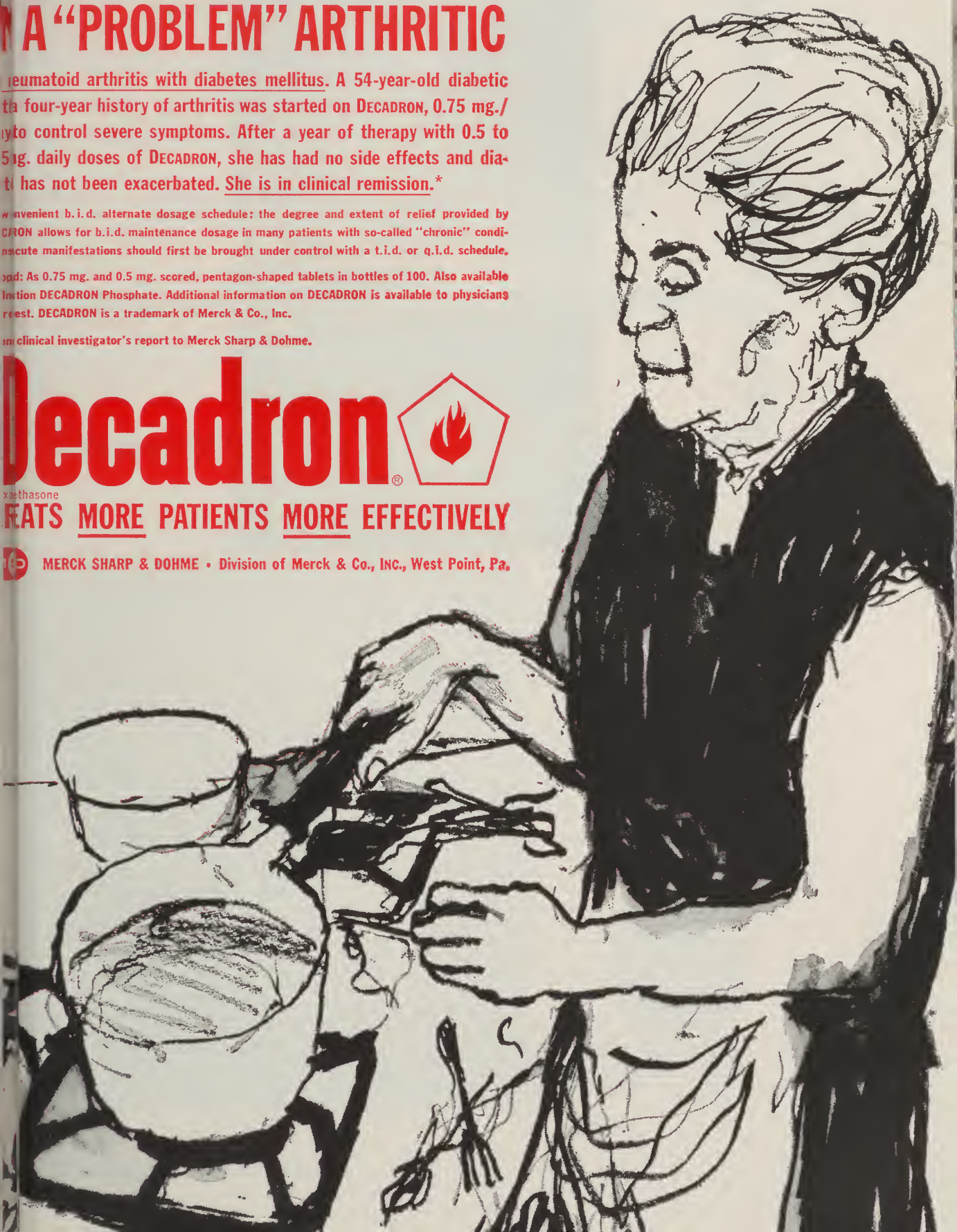
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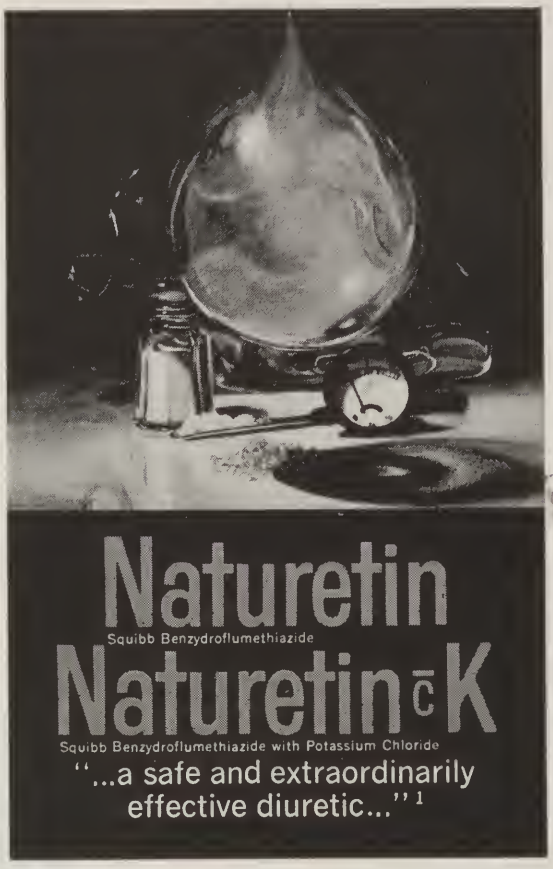
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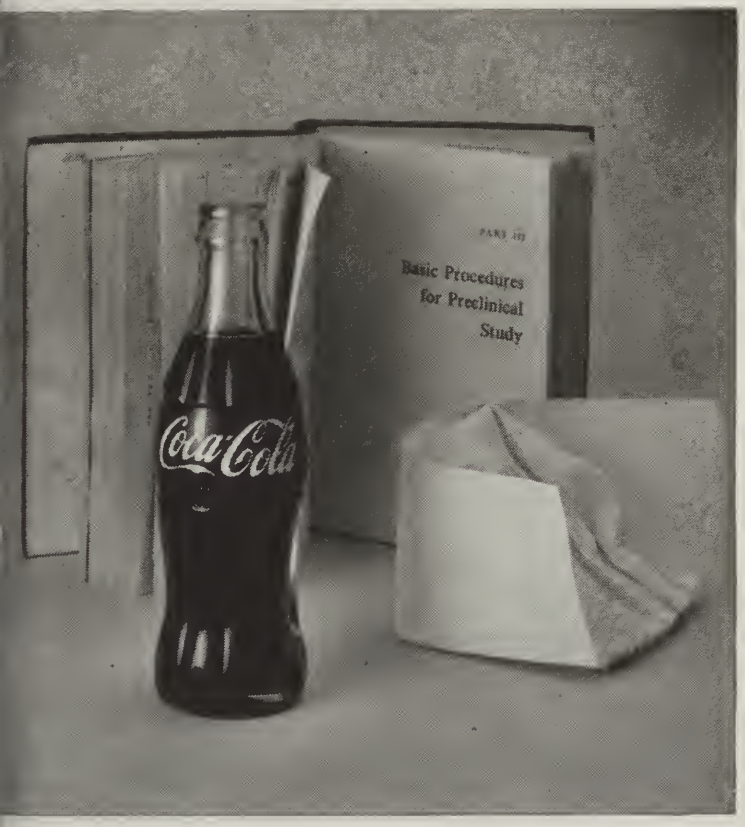
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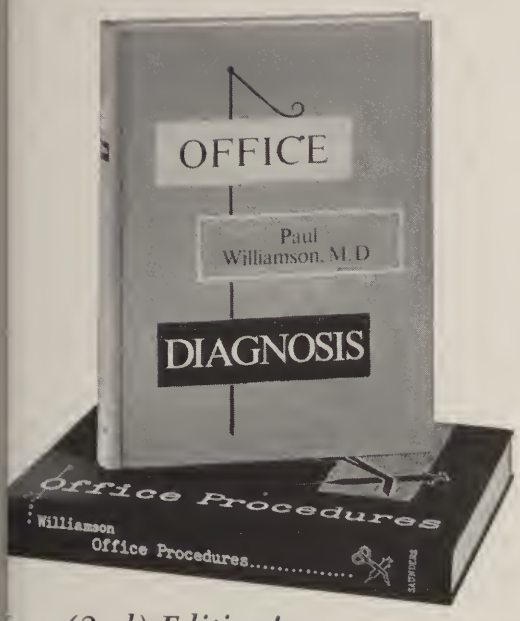
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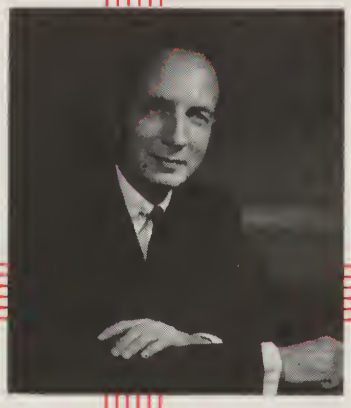
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MESSAGE FROM THE PRESIDENT

Medicine's Political Climate

Physicians have in the past wisely declined to dabble in the muddy water of politics. They have traditionally avoided active participation in party organization and have refused to become involved in local political campaigns. There are sound, substantial reasons for not assuming an active, aggressive role in local elections. No one would deny the fact that partisan politics can both lose friends and alienate patients.

On August 14, 1935, when President Roosevelt signed the Social Security Act, the movement for enactment of a federal compulsory health insurance program began in this country. The Truman Administration in 1948 supported the Wagner-Murray-Dingall bills. A bitter controversy raged through the political campaigns of 1950, when some of the principal proponents of these bills went down to a crushing defeat. And now, after 10 years, this issue in the form of the Forand Bill has again been introduced into Congress.

The Social Security Act has been liberalized each even year (election year) since its enactment into law. The Forand Bill is a proposed change in this same act in yet another election year, which would change forever the fundamental principle of the Act. The Act has furnished to its beneficiaries retirement benefits in the form of cash which they could spend according to their wishes and needs. The Forand Bill would give them not additional cash but a service which would be under the complete control and dircction of the Federal Government. This bill would further establish the principle that the Federal Government is directly responsible for the health of our people.

There are loyal, dedicated groups of people in Washington who classify medicine as a service. They believe that the best interests of this country can be achieved by regulating this service along with other services, such as public utilities, communications and transportation. By failing to become identified with political campaigns or to participate in partisan politics, the physicians have much to lose: the private practice of medicine as an institution, the high standards of medical care, and the freedom of individual opportunity .

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THE INSURANCE PAGE



The Prepayment Plan

OFTEN the statement is flatly made that doctors increase their charges when they find that the patient has Blue Shield or insurance. Such a thought in the minds of many people must be taken into consideration by the medical profession.

If any doctor should charge more because the patient has a prepayment plan, he is nullifying the entire purpose for which the plans are established. No patient should be requested to pay more simply because he has budgeted in advance to help meet his responsibility to his doctor and to the hospital. Prepayment creates no new wealth.

The need for prepayment is plain. When hospital-surgical care is necessary, only one person out of ten could make the payments to the doctors and hospitals out of savings. We are in a time-payment economy, and the average family budgets its income on the basis of monthly payments for practically all consumer purchases. There is little cash in hand. Recognizing this fact, doctors and hospitals have had to originate an orderly approach for prepayment of health care.

As everyone who has contacts with workers and industry knows, take-home pay looms as a very important thing to employees. In spite of this, thousands of these people are having monthly payments taken out of their pay check to enable them to meet their obligations to the doctors and the hospitals when health care needs arise.

It is necessary for organized medicine and the individual doctor not only to be aware of the extent of this thought in the public mind, but also to be willing to take any steps within their power to prevent increased charges because a patient has a prepayment plan, and thus to dispel this feeling.

W. Vinson Pierce, M.D.

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NEW
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to relieve both nasal
and chest discomfort

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provides both . . . / **upper respiratory decongestion and bronchial decongestion**

Many hay fever patients also experience chest discomfort. For these patients, new ISOCLOR provides relief along the entire respiratory tract.

COMBINES the nasal and bronchial decongestant action of d-isoephedrine with the histamine blocking action of chlorpheniramine.

RELIEVES the discomforts of rhinorrhea, itching, sneezing, hyperlacrimation and post nasal drip—lets the patient get a full night's rest—with minimal daytime drowsiness, CNS or pressor stimulation.

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COMPOSITION:	Per tablet	Per 5 ml. syrup
Chlorpheniramine maleate	4 mg.	2 mg.
d-Isoephedrine HCl	25 mg.	12.5 mg.

DOSE: Tablets: One tablet 3 or 4 times daily. Syrup: Children: 3-6 yrs. ½ tsp. t.i.d.; 6-12 yrs. 1 tsp. t.i.d.; Adults: 2 tsp. t.i.d.

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WASHINGTON NEWS DIGEST



Washington, D.C.—Congress returned to work this month to take up its unfinished business, including the controversial issue of health care for the aged, an atmosphere dominated by election-year politics.

The three or four-week, tag-end session of Congress loomed as one of the most important meetings in the past decade as far as possible impact on the medical profession is concerned.

The lawmakers are slated to decide whether to embark the Federal Government on a course that could threaten the private practice of medicine, or to adopt a voluntary program that would pose no such danger.

Bill Has AMA Endorsement

The omnibus Social Security bill approved by the House Ways and Means Committee was easily cleared by the House, 381 to 23, and sent to the Senate Finance Committee, which held two days of hearings. The measure contained a voluntary, Federal-State program for assisting needy aged persons meet their health care costs. Both the Administration and the American Medical Association endorsed the House measure as in keeping with the concept of giving the states prime responsibility for helping their citizens, for aiding those who are most in need of help, and for avoiding the compulsory aspects of health plans involving the Social Security mechanism.

A vote by the Finance Committee, headed by Sen. Harry F. Byrd, (D., Va.) was scheduled shortly after the Senate resumed operations in August. Whatever action the Committee took, however, proponents of schemes such as the Forand bill to provide a compulsory, federal medical program promised a determined fight on the floor of the Senate.

Veto of Compulsory Plan Expected

In the event Congress should approve a government medicine plan, opponents were counting on a Presidential veto to kill the measure. The Chief Executive repeatedly has asserted in strong language his all-out opposition to any compulsory plan for health care financing.

At the Senate Finance Committee hearing, Arthur S. Flemming, Secretary of Health, Education and Welfare, renewed the Administration's flat stand against the Social Security avenue to financing health costs. Such a plan, he said, would inevitably lead to pressures for expanding the benefits and lowering or eliminating the age requirement. Under such circumstances, a 15 per cent or 20 per cent Social Security payroll tax would not be too far off, he said. "We believe it is unsound to assume that revenue possibilities from a payroll tax are limitless."

Dr. Larson Speaks For AMA

Leonard W. Larson, M.D., president-elect of the American Medical Association, told the Committee the House bill is the "antithesis of the centralized, socialized, statist approach of the proposals advocating national compulsory health insurance."

"To those critics who call this program modest, we say that fiscal irresponsibility, unpredictable cost and maximum nationalization are not the accepted criteria for good legislation," he testified.

A spokesman for the insurance industry pointed out "giant strides" made by private health insurance in recent years in covering aged persons. E. J. Faulkner declared that one of the most prevalent and erroneous assumptions on the matter is that most of the aged aren't able to contribute to financing their own health care costs.

Undesirable Consequences

The Social Security health bills, he said, "would impair or destroy the private practice of medicine, would add immeasurably to our already crushing tax burden, would aggravate our severe public fiscal problems, and would entail other undesirable consequences."

In other testimony, the AFL-CIO again urged enactment of a Social Security health bill; the American Optometric Association and the International Chiropractors Association urged that health benefits included in any bill include the services of osteopaths and chiropractors, respectively.

On another legislative proposal of interest to the medical profession—the Keogh-Simpson bill—a Senate debate was scheduled this month. Sen. Gordon Allott (R., Colo.) said in a Senate speech that "I believe that this legislation will have the overwhelming support of this body."

The bill, which would encourage retirement savings by the self-employed such as lawyers, small businessmen and physicians, has already been approved by the House. The Senate bill, voted by the Senate Finance Committee, would require participating self-employed to establish retirement plans for their employes.



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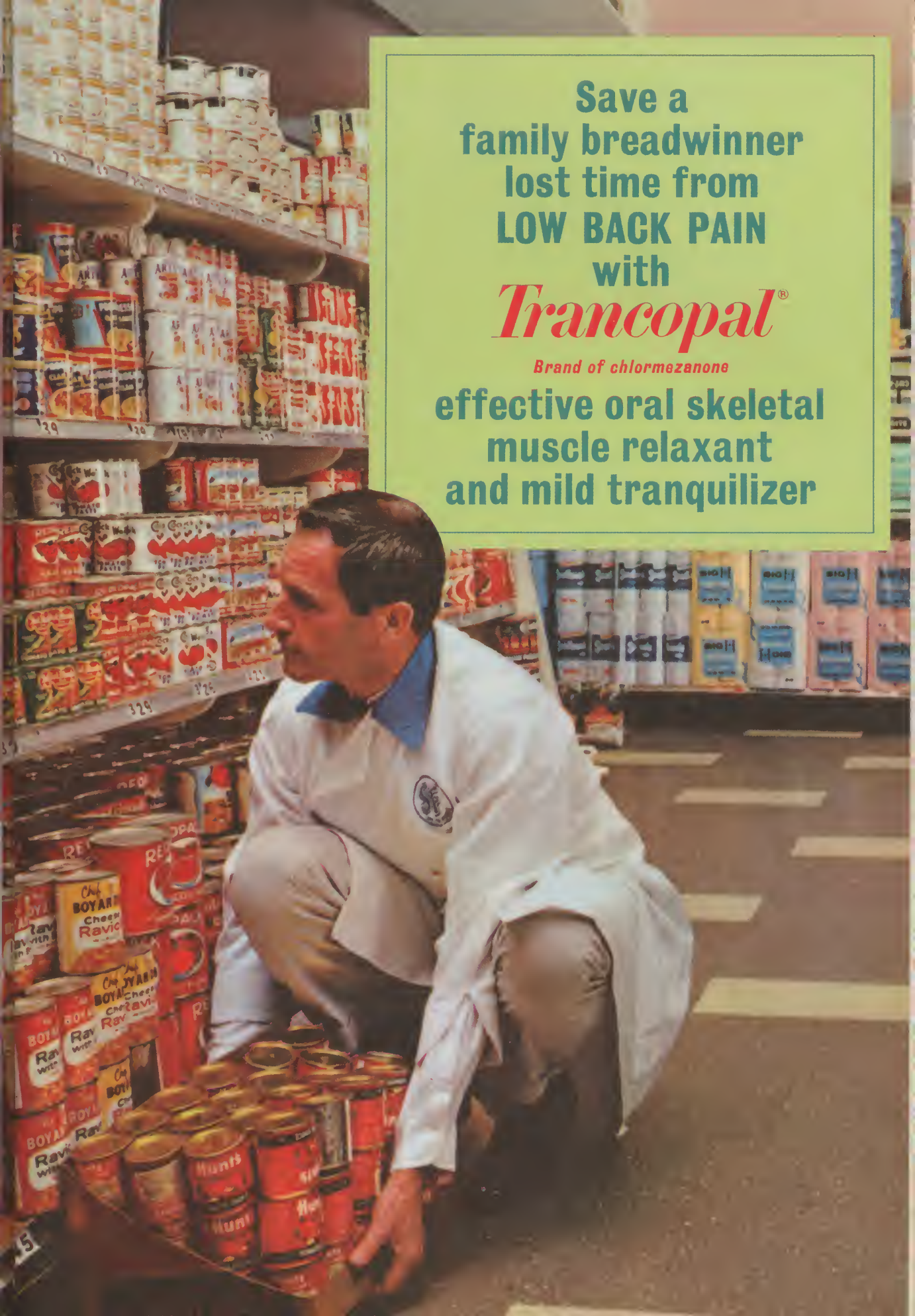
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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

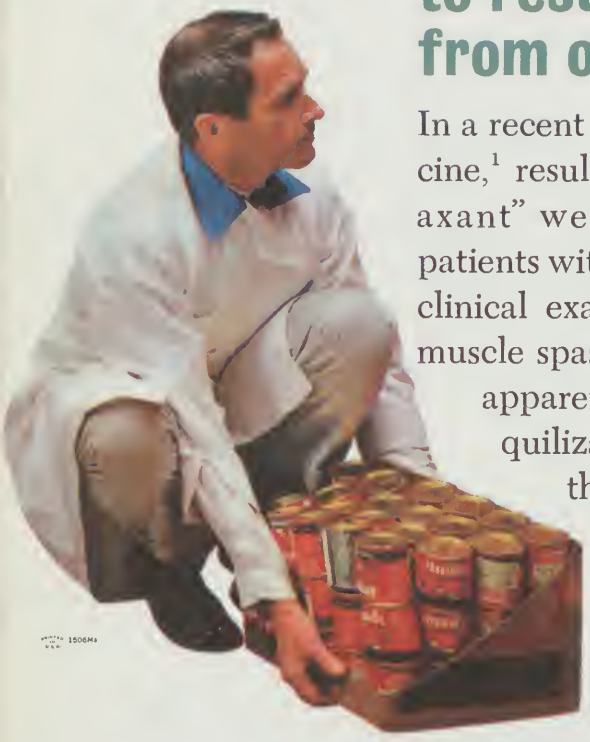
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	Excellent	Good	Fair	Poor	Total
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Acute low back strain	25	19	8	6	58
Chronic low back strain	11	5	1	1	18
"Porters' syndrome"*	21	5	1	1	28
Pelvic fractures	2	1	—	—	3
CK SYNDROMES					
Whiplash injuries	12	6	2	1	21
Torticollis, chronic	6	2	3	2	13
HER MUSCLE SPASM					
Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
NSION STATES	18	2	4	3	27
TALS	112 (51%)	70 (32%)	23 (10%)	15 (7%)	220 (100%)

*Over-reaching in lifting heavy bags resulting in sprain of upper, middle, and lower back muscles.

Dosage: **Adults, 200 or 100 mg. orally three or four times daily.**
Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

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200 mg. (green colored, scored), bottles of 100.
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1. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960.

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Dietary Linoleic Acid and Linoleate—*Effects in Diabetic and Nondiabetic Subjects with and without Vascular Disease*

A paper by Laurance W. Kinsell, M.D., et al., excerpted from Diabetes—The Journal of the American Diabetes Association, May-June 1959

"*Linoleic acid as the major 'hypocholesterolemic agent' in vegetable fats.* The question has been raised as to the mechanism of lowering of the plasma lipids by a variety of vegetable fats. Among the entities present in or absent from vegetable fat which have been considered are: (a) the absence of cholesterol; (b) the presence of certain vegetable sterols; (c) the presence of certain vegetable phospholipids; (d) the nature of one or more of the fatty acids present; (e) the presence of trace materials.

n the diet

The absence of cholesterol has been excluded as a major factor.[5a] Phospholipids, if they contain a sufficient quantity of unsaturated fatty acids may produce a striking reduction. In our experience thus far saturated phospholipids fail to produce such an effect.[7]

Beveridge and his associates believe that vegetable sterols, particularly beta-sitosterol, are responsible to a significant degree for the cholesterol-lowering effect.[8] In our experience the vegetable sterols have a relatively weak and unpredictable effect of this sort.

Since the fatty acids of animal fats are predominantly saturated, and the fatty acids of most vegetable fats are predominantly polyunsaturated, with linoleic acid as the major component of the vegetable fats which lower cholesterol and other lipids, the question arises whether linoleic acid per se is capable of lowering plasma lipids. As reported previously[7] this is indeed the case. In a recent study in a young male with peripheral atherosclerosis in association with elevation of plasma cholesterol and of total lipids, ethyl linoleate produced a greater fall in the plasma lipid levels than had moderate amounts of natural sources of unsaturated fat. Linoleic acid, therefore, appears to be the most important single lipid-lowering component of vegetable fat.

* * *

Significantly higher levels of cholesterol were observed during oleate administration than during administration of equal amounts of linoleate. The relatively low cholesterol values during the second oleate period may have been related to linoleate stored in fat depots. The fatty acid composition of the cholesterol esters reflected the fat which was fed, i.e., the mono-enoic† acid content averaged more than 40 per cent during oleate feeding and less than 20 per cent during linoleate ingestion. Essentially, a mirror image of this resulted during linoleate feeding, at which time di-enoic acid predominated.

* * *

The data presented in this paper appear to establish that linoleic acid administered either as purified ethyl ester or as naturally occurring fat, in sufficient quantity, in properly constructed diets, will reduce plasma lipids to normal levels. The amount of linoleic acid required appears to bear a direct relationship to the amount of saturated fat included in the diet. Linoleic acid requirement may also bear a significant relationship to the amount of atherosclerosis present.

The transition from evaluation of the effect of dietary entities upon plasma lipids, to the evaluation of the effect of such materials upon vascular disease is difficult. However, such evaluation is not impossible. The requisites are adequate measuring sticks and well-controlled studies of sufficient duration. The duration of observation of effects of unsaturated fat in diabetic and nondiabetic patients with vascular disease is in no instance more than five years, and in the majority of instances, less than three. Our present impression is that improvement has occurred in some patients with atherosclerosis and with diabetic retinal and renal disease which was more than we would have anticipated in terms of the natural course of the disease. However, since it is well known that major fluctuations in these diseases can occur in individuals receiving no treatment, we believe it is appropriate at this time to say that no untoward effects appear to result when one prescribes diets containing large amounts of unsaturated fat for patients with such diseases, and it is not impossible that beneficial effects may be associated with such diets."

* * *

5a Kinsell, L.W., Partridge, J. W., Boling, L., Margen, S., and Michaels, G.D.: Dietary modification of serum cholesterol and phospholipid levels. J. Clin. Endocrinol and Met. 12:909, 1952.

7 Kinsell, L. W., Friskey, R., Splitter, S., Michaels, G. D.: Essential fatty acids, lipid metabolism, and atherosclerosis. Lancet 1:334, 1958.

8 Beveridge, J.M., Connell, W.F., Firstbrook, J. B., Mayer, G.A., and Wolfe, M.J.: Effects of certain vegetable and animal fats on plasma lipids of humans. J. Nutrition 56:311, 1955.

† Mono-enoic (mono-unsaturated) acid is presumably synonymous under these conditions with oleic acid and di-enoic (di-unsaturated) acid with linoleic acid

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Outstandingly Safe

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for the tense and nervous patient



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Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

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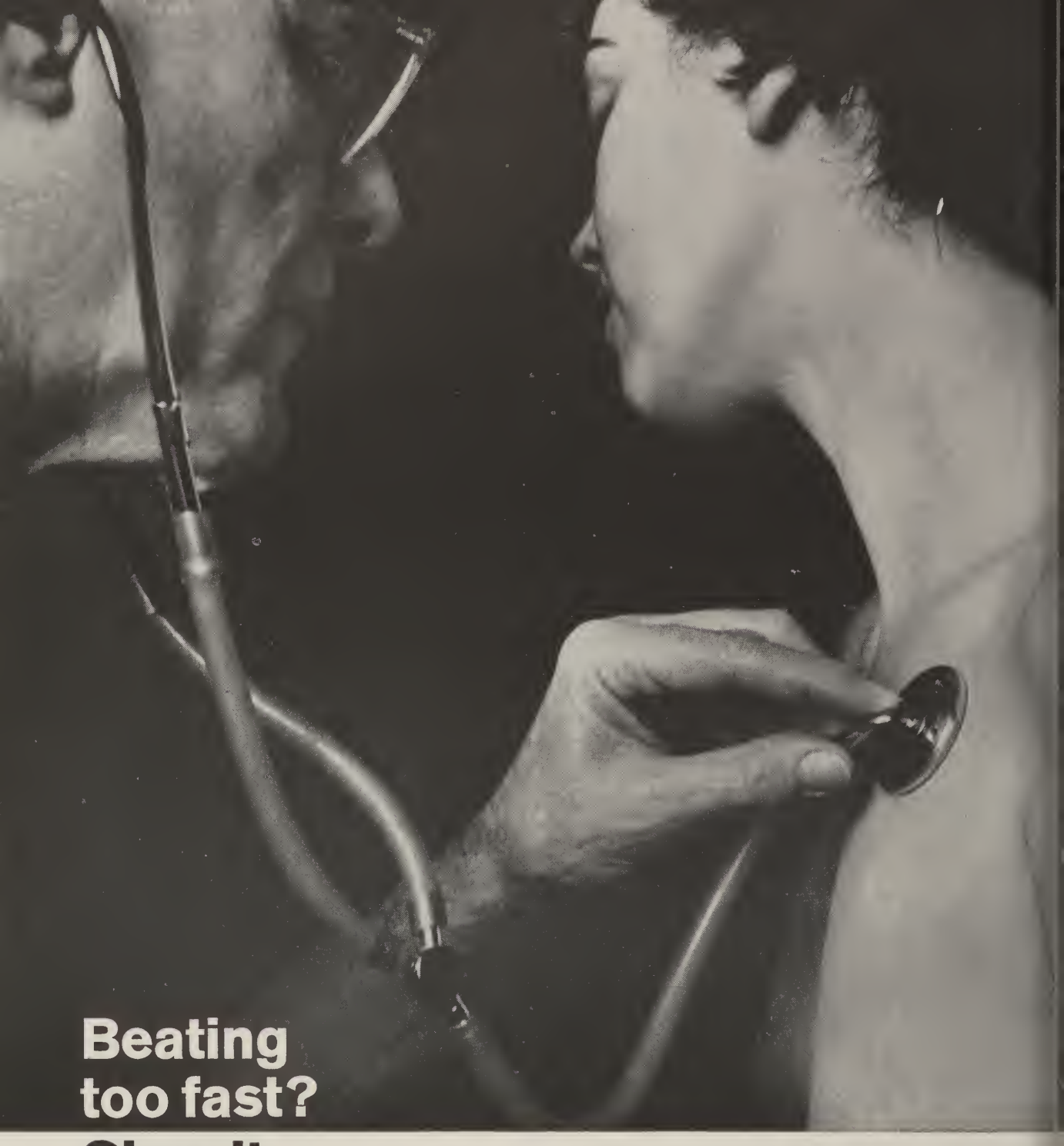
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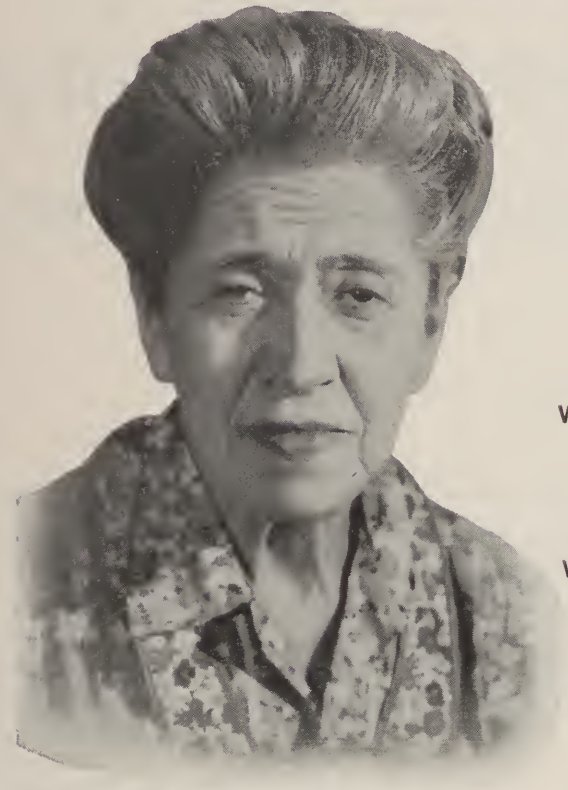
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References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

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The JOURNAL of the
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ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 58 AUGUST, 1960 NO. 8

The Pathogenesis Of Coronary Sclerosis*

JAMES T. McCLELLAN, M.D., M.S.†

Lexington, Ky.

Coronary sclerosis is not caused by any one condition but by a chain of events in which the final disease must be preceded by definite stages influenced by the total environment

THREE common types of degenerative or sclerotic changes are recognized within the walls of arteries. These changes are designated as (1) intimal sclerosis, (2) medial sclerosis, (3) arteriosclerosis. It is the first mentioned type of sclerosis that is important in coronary artery disease, and this paper deals only with the development of intimal sclerosis, which was designated by Marchand[1] in 1904 as atherosclerosis.

Intimal sclerosis, or atherosclerosis, is a change universally occurring in the aorta and the major branches of the aorta, including the coronary arteries. Every living adult person will show some degree of atherosclerosis, and every child from all parts of the world will show the beginning of this change after the age of 3. By 10 years of age, the process is established. These may be rather all inclusive statements, but these facts have been borne out by the work of Holman[2,3] and others over a good many years of study and observation.

Stages of Atherosclerosis

In studying the course of atherosclerosis and its effect on the body it is well to divide the condition into stages. It is also recognized that each stage in the process of the condition is arrived at by the development of the preceding stage.[2,3]

The earliest recognizable change of atherosclerosis is the "fatty streak."[2] This lesion can be demonstrated with appropriate measures both grossly and microscopically in every aorta beyond the age of three years. In 1903 Jores[1] recognized that the small white and yellowish streaks of thickening found in aortas of young individuals were the beginning of intimal sclerosis. The lesion begins with intercellular and extracellular globules of lipid and a slight increase in interstitial mucous material in the intima of vessels.[2] This process is the same in coronary arteries as in the aorta or large vessels. The intima is not always elevated at first and early there is no fibrous reaction.

During the second decade of life the fatty streak is gradually invaded with fibrous tissue and converted to a "fibrous plaque".[2] This is the second stage of the condition. At the base of such plaques a core of lipid remains which serves to indicate the origin of the plaque. As

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the fibrous plaque develops, the lumen of the vessel is compromised, particularly if another plaque is opposite it. Fibrous plaques increase in number with age and Holman reports that after thirty years of age ninety per cent of aortas of all races studied revealed fibrous plaques to some degree.[2,3]

Fibrous plaques may remain dormant for many years; however, with time these lesions may be complicated in a number of ways and this initiates the third phase of the disease; namely, "complication of lesion."[2] It is unusual to see complications before the age of forty. As the plaque enlarges it may ulcerate and be the seat of thrombus formation plugging the lumen of the vessel. It may become vascularized and undergo hemorrhage and thus may cause a vascular accident. Adjacent and opposite plaques may produce stenosis and virtual occlusion to the flow of blood or the plaque may grow by the process of accretion with further deposit of lipid on the surface followed by organization. Any of these complications or combinations of them will bring about recognizable clinical manifestations depending upon the organ and area involved. Thus "clinical disease" is the fourth stage of atherosclerosis.[2]

Since fatty deposits universally occur in the intima of arteries it appears that factors other than those which initiate the deposit of lipid are responsible for the succeeding stages of arteriosclerosis; namely, the fibrous plaque, the complicated lesion, and the clinical disease.

Predisposing Factors

For many years there has been an extensive search for predisposing factors to atherosclerosis. Most authors recognize three major predisposing factors. These are heredity, diet, and stress. Depending upon the author's viewpoint one of these may be stated to be relatively more important than the other. Thus Holman has emphasized heredity, racial, and hormonal influences in the development of atherosclerosis.[2,3] Dock[4] focuses attention on eating, drinking, and smoking and Russek[5] notes the effect of stress in the production of coronary disease in young individuals.

As long ago as 1908, nodular intimal lesions in the aortas of rabbits were produced by feeding a diet of meat, milk, and eggs.[6] This diet is high in lipid content and cholesterol and is entirely foreign to the vegetable diet of the rabbit. Later it was shown that atherosclerosis was produced in rabbits on a diet of vegetable oil with pure cholesterol. Results were obtained only when high values of cholesterol were ingested.

The same experiments, when applied to carnivorous animals, were negative until it was found that the addition of thiouracil along with experimental feeding of cholesterol would produce experimental atherosclerosis in dogs similar to the lesions seen in man. Serum cholesterol levels above 450 mg. per cent had to be maintained for more than twelve months in order to produce atherosclerosis lesions in dogs.[6] These lesions are produced only under experimental conditions which are rarely if ever duplicated in the life of man. While high fat content in the diet must be considered a contributing factor, it is now understood that it is not the only factor.

Stress and High Fat Diet

Stress has been shown to be a contributing factor in coronary disease in all young males with symptoms relating to coronary artery disease.[5] However, stress appears to initiate coronary disease only in association with a high fat diet. According to Seifter[5], stress stimulates the anterior pituitary to secrete ACTH, which in time stimulates the adrenal cortex with the formation of increased amounts of gluco-corticoids. These substances act upon the posterior pituitary to release a lipid-mobilizer substance which acts on fat deposits and releases neutral fat into the portal circulation. The liver may not be able to cope with the fat in such conditions and neutral fat and cholesterol reach the peripheral circulation. It has been shown that stress when associated with starvation or low fat diet is not predisposing to coronary disease and its complications.[5]

It would appear from the standpoint of the pathologist that the cause and effect of coronary arteriosclerosis is related to many influences, some of which may be unmeasurable, at least at the present. Since the basic changes seem to be universal in arteries of all adults it appears that at least part of the chain of events is related to aging.

The rapid rise of lesions during the years of

puberty suggest a relationship to changing hormonal environment. The earlier development of lesions in men indicate an influence from masculinizing forces. When one stops to consider that these or related changes are taking place in all collagen-bearing tissue of the body one must realize that efforts in our meat producing industries are designed to thwart these same processes. Thus cattle are brought to maturity at an accelerated rate by controlled diets containing stilbestrol products and male animals whose flesh is to be eaten are demasculinized. We have all had the experience of the tough steak and who would call this process disease. Yet it is on this process that disease is built.

Summary

In summarizing the concepts of the pathogenesis of atherosclerosis of the coronary arteries, it is apparent that no clear-cut etiological relationship exists or emerges from the study of the disease as it exists in various peoples and races of the world. The basic changes develop in all people as part of the process of growth, development, metabolism and aging. This rate of change may be governed to some extent by the individual's hereditary makeup and is further changed by changing hormonal environment of the tissues; thus, the relationship to some diseases such as diabetes and hypertension may be perceived if not yet understood.

The effect of diet and emotional stress may further accelerate development of the lesion producing irreversible pathological changes resulting in clinical disease in individuals in whom the stage is set by heredity, hormonal makeup, and age.

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The Treatment Of Acute Myocardial Infarction*

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Review of 137 cases shows relatively low mortality rate. Careful attention to management, routine use of anticoagulants and early recognition of complications are stressed

THE purpose of this paper is to discuss the treatment of acute myocardial infarction and to report the experience of the Medical Section of the Lexington Clinic with 137 patients hospitalized because of acute myocardial infarction between January 1950 and March 1959.

Included in this group are all patients in whom the diagnosis of acute myocardial infarction could be established with reasonable certainty. Of the 137 patients, 100 were males and 37 were females. Except for two Negro males, all patients of the series were white. The over-all average age of these patients was 64 years; the average age of male patients being 61.8 years and that of female patients 70.2 years.

Mortality

The over-all mortality within the period of hospitalization was 28.5%, with the male mortality being 24% and the female mortality 40.5%. This mortality rate may be compared with recent studies from Ohio State University[1] in which the mortality rate for men was 38% and for women 45%. Many patients in our group died within a few hours after reaching the hospital. There was, interestingly enough, little age difference between those who died and those who survived as shown in Table 1.

Anticoagulants

Anticoagulants were routinely used, although in 11 instances death occurred before anticoagulation therapy could be started and four others were not treated because of contraindications. In the 122 patients treated with anticoagulants there were no significant untoward effects. We feel that this notable lack of complications was due to careful following of the daily prothrombin times. Anticoagulants used included Heparin, Dicumarol, Tromexan®, Hedulin®, and Coumadin®; all proved satisfactory. Some of us believe that Coumadin® may have a slight advantage since therapeutic levels may be reached earlier than with Dicumarol or Hedulin. Although the presence of pericarditis following a myocardial infarction has been mentioned as a relative contraindication in the use of anticoagulants, we have used anticoagulants on several patients with pericarditis without untoward effect.

TABLE I

Mortality and Age at Death

	Total	Male	Female
Patients	137	100	37
Age	64	61.8	70.2
Mortality	39	24	15
	(28.5%)	(24%)	(40.5%)
Age of death	67.8 yr.	62.4	73.3

Twenty-five patients died while on anticoagulation therapy, but in no instance was a thromboembolic complication responsible. On the other hand, there were five possible thromboembolic complications in the treated group who survived, an incidence of 5.6%. There was one pulmonary infarction and there were four cerebral vascular accidents which

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may have been caused by embolism from a mural thrombosis. It is interesting that all of these complications occurred within the first three days of hospitalization. In at least one of these patients therapeutic levels of prothrombin suppression had not been reached.

Complications

Shock developed in 14 patients, or about 10% of the entire group; of these 14 patients with shock, eight died. Four of these deaths occurred before effective vasopressor substances were available. In one instance, continuous intravenous norepinephrine was needed for 21 days; this patient survived.

Shock is one of the most serious complications of myocardial infarction. Early detection of shock is essential for successful treatment. One should start treatment while shock is still impending and not wait until it is irreversible. The blood pressure should be recorded at frequent intervals. Even more important is careful observation for clinical signs of impending shock. These, in addition to cold moist skin, may be apprehension, mental confusion and oliguria.

When shock is present or impending, we believe a vasopressor agent should be started at once. Levophed® or norepinephrine is the most potent and has been the most widely used. It has the disadvantage of causing subcutaneous or skin necrosis if it leaks outside the vein. The slough may be averted by the subcutaneous injection of Regitine® at the site of inflammation. Recently, Aramine®, a somewhat less potent vasopressor substance, has been introduced; this agent has the advantage of subcutaneous or intramuscular use as well as intravenous use.

Congestive heart failure developed in 17 patients (12.4%) of our group. In 12 instances the heart failure was progressive and fatal despite treatment. In five patients symptoms of congestive heart failure were marked but they responded to the usual treatment with oxygen and diuretics. Digitalis was used when congestive failure did not respond to these measures.

Surprisingly, significant cardiac arrhythmia developed in only three instances. Two patients had paroxysmal auricular fibrillation with rapid ventricular rate. The ventricular response in both instances was controlled by digitalis and later normal sinus rhythm became established spontaneously. The third patient developed paroxysmal ventricular tachycardia. Pronestyl® was given intravenously with resulting disappearance of the arrhythmia.

Serious persistent pericarditis developed in two patients, but neither required pericardial tap. Transitory pericardial friction rubs were heard in many patients and small amounts of pericardial fluid were noted at autopsy in several patients in whom it was not significant clinically. Cardiac rupture occurred in four patients who were autopsied and may have caused death in others. Complications of acute myocardial infarction in our series of 137 patients are listed in Table 2.

Rest

Rest is a traditional principle in the treatment of acute myocardial infarction; it remains of fundamental importance. Most deaths and practically all myocardial ruptures occur within the first 14 days. Thirty-eight of 39 deaths in our series occurred in the first two weeks.

TABLE 2

Complications	Total	Deaths	Survivals
	137	39	98
Shock	14	8	6
Congestive failure	17	12	5
Arrhythmia	3	—	3
Pericarditis	2	—	2
Pulmonary embolism	1	—	1
Cerebral embolism	4	—	4
Rupture	4	4	—
Sudden death	14	14	—

We believe that all patients should be treated in bed for at least two weeks. Those who are thought to have had minor infarctions may be allowed to sit up at the end of this time and are usually discharged from the hospital at the end of three weeks. Others with clinical evidence of large infarction, or with complications, usually are treated with more prolonged periods of bed rest, sometimes from four to six weeks. Most of the patients were back to work in two to three months. All patients were allowed to use the bedside commode after the first day or two unless they were in shock.

We pay particular attention to bowel movements since fecal impaction is a serious complication. If the patient has not begun to have regular bowel movements by the end of two to three days, we usually use mineral oil, Dulcolax® suppository or small enemas.

Ordinarily, the patient is given a soft, small-

feeding diet the first week in the hospital. Later, if serum cholesterol is high he is given a diet high in unsaturated fats and low in saturated fats.

Oxygen was used initially in many of the patients in this series. Ordinarily, it is used only when cyanosis is present or if pain is persistent and not relieved by narcotics.

For the relief of pain and apprehension, morphine remains the drug of choice. The next most commonly used narcotic in this group is Demerol® which may be used from the beginning or after morphine has relieved the initial pain. Sedation may also be very important in a nervous or agitated patient. Often no daytime sedation is necessary but if it is advisable, phenobarbital is commonly used.

At the Lexington Clinic we have long agreed with the proponents[2] of treating all cases of myocardial infarction with anticoagulants provided there are no known contraindications such as bleeding tendency, active gastrointestinal hemorrhage or liver disease, and provided reliable prothrombin time determinations are available.

Summation

I believe this series of cases has demonstrated the relative safety in the careful use of anticoagulants and the low instance of thromboembolic phenomenon in the treated cases. The reduction in the over-all mortality is best explained by the reduction in the incidence of thromboembolism. Although the cause of death was uncertain in many of these patients, I believe the majority can be explained by congestive heart failure, shock, ventricular fibrillation, or extension of the original thrombus. These are the areas in which improvement in therapy must occur, if further reduction of mortality in myocardial infarction is to be obtained.

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The Operation Of Choice For Duodenal Ulcer

GILES L. STEPHENS, M.D.*

Louisville, Ky.

The operation of abdominal vagotomy, antrectomy and gastroduodenostomy is recommended as the surgical treatment for duodenal ulcer, based on physiologic and clinical evidence

LESTER Dragstedt has demonstrated that the continuous fasting secretion of gastric juice in man is of neural origin and is usually increased several fold in patients with duodenal ulcerative disease. Complete vagotomy entirely abolishes this secretion. J. S. Edkins[2] has stated that a gastric secretory hormone is liberated from the antral mucosa in response to the presence of food, distension of the antrum with gas, and by peristaltic activity. Experimental work in animals has demonstrated that the gastric antrum is the sole source of the hormone "gastrin;" it appears that a comparable situation exists in man. Antrectomy entirely eliminates this phase of gastric secretion.[1,7,8]

The combination of vagotomy and antrectomy eliminates both the neural (vagal) and the hormonal phase of gastric secretion. Herrington et al.[4] state that the combined procedure is appropriate for the management of the massive bleeder who requires surgical intervention, and they also believe it is applicable to the patient with an acute perforation of a duodenal ulcer.

Some authors question the desirability of entering the mediastinum to perform the abdominal vagotomy in the presence of marked soilage of the intraperitoneal space. I believe it is the surgeon's main responsibility to save life in these cases of perforation and recommend suture of the perforation. Definitive gastric surgery is best performed at a later time under more ideal circumstances in those patients who will require this form of therapy.

One of the major advantages of performing a limited distal gastric resection is that a larger gastric pouch will remain. A major function of the intact stomach is to serve as a reservoir for the mixing of foods. It only appears rational that the larger the gastric reservoir the slower the gastric pouch would be emptied of its contents into the duodenum or jejunum. In Palumbo's series[6] there was an incidence of dumping syndrome of 17 per cent in their subtotal gastrectomy group as compared to an incidence of four per cent in their antrectomy-vagotomy series.

Postoperative Rehabilitation

The surgeon's responsibility does not end with the cure of the duodenal ulcerative disease, but continues until the patient has been maximally rehabilitated as far as weight, strength and work capacity are concerned. All surgeons are familiar with the anemia which develops following total gastrectomy or radical subtotal gastrectomy. In Herrington's group anemia was only rarely encountered. It has been demonstrated that there is better protein and fat absorption with a gastroduodenostomy than with a gastrojejunostomy. It is also known that iron absorption is superior in the patient who has had gastroduodenostomy as compared to the patient who has had gastrojejunostomy.

Of Herrington's 565 patients who had abdominal vagotomy and antrectomy, 175 patients had a gastroduodenostomy with excellent functional results in 59 per cent whereas there were 339 patients in this series who had a gas-

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trojejunostomy, with 63 per cent obtaining an excellent result. It is of further interest that of the group of patients having the gastroduodenostomy (Billroth I) there was an incidence of dumping syndrome of 29 per cent. The dumping was mild in most of these patients, and there was not a single case of severe postprandial dumping syndrome.

In the gastrojejunostomy group (Billroth II), the incidence of the dumping syndrome was 30 per cent, and the symptoms were mild and transient in the majority of the cases; however, three patients had severe symptoms and two of these patients became totally functionally incapacitated and required conversion of the gastrojejunostomy to gastroduodenostomy. Both of these patients are now completely rehabilitated from a nutritional standpoint. The third patient with the severe symptoms has lost 50 pounds in weight over a period of several years.

Herrington states that the majority of his patients have not lost weight below their average or ideal weight. In Palumbo's series all the patients having antrectomy-vagotomy gained weight postoperatively. In this group of patients having subtotal gastrectomy only 40 per cent gained weight, 42 per cent lost weight and 18 per cent maintained a stable weight.

Recurrent Ulceration

The incidence of recurrent ulceration in Herrington's group was .38 per cent (2 cases). One of these two cases was demonstrated to have recurrent ulceration on the basis of an incomplete vagotomy. The other patient had a postoperative Hollander test which demonstrated complete abdominal vagotomy, and has had no further difficulty following resection of the gastric pouch. Griffith and Harkins[3] demonstrated that the proximal duodenum in man is better equipped to intrinsically resist acid-peptic ulceration on the basis of its Brunner's glands. There are no Brunner's glands in the jejunum to protect against peptic ulceration; this is another reason for advocating gastroduodenostomy over gastrojejunostomy.

The operative mortality in Herrington's series was 3.1 per cent among 565 patients. However, if the mortality was corrected by exclusion of the patients who were operated on for massive hemorrhage, the resultant mortality rate was 1.7 per cent. This latter figure falls within an acceptable range for the surgical treatment of duodenal ulcer.

If faced at the time of surgery with a duodenal ulcer which is penetrating into the head of the pancreas I would recommend abdominal vagotomy and pyloroplasty as championed recently by George Crile, Jr., of the Cleveland Clinic. In a study of the Ohio Chapter of the American College of Surgeons, covering more than 2,000 operations performed for duodenal ulcer, Stanley O. Hoerr reported that their mortality for procedures involving gastric resection was 4.9 per cent. For operations with drainage procedures without resection their mortality was 1.7 per cent. There is a three-fold difference in these mortalities. Of 100 cases having vagotomy and posterior gastroenterostomy, and observed more than five years thereafter, Stanley O. Hoerr found that nearly 90 per cent obtained good clinical results.

The extirpation of the posterior wall duodenal ulcer that is penetrating into the head of the pancreas is fraught with considerable danger. The most frequent complications are postoperative pancreatitis, pancreatic fistulae, and injury to the common bile duct with its known sequelae.

Summary

The operation of abdominal vagotomy, antrectomy (45% distal gastrectomy), and gastroduodenostomy is recommended as the surgical treatment for duodenal ulcer. For those patients having a posterior wall duodenal ulcer with penetration into the head of the pancreas, abdominal vagotomy and pyloroplasty is recommended as the operation of choice.

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Topical Therapy With Triclobisonium Chloride In Dermatologic Practice

Robert J. McCabe, M.D.

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Edwin L. Higgins, *M.D.*

Triclobisonium Chloride proves to be a satisfactory antibacterial drug. Its use avoids the development of organism resistance to the more commonly used antibiotics

ALTHOUGH antibiotics have produced therapeutic wonders since their introduction in dermatologic practice, it is apparent from the literature and clinical experience that their widespread use, not only in dermatology but in other fields as well, has wrought profound changes in the number and character of infections that are appearing in hospitals.[1] Widespread epidemics of infections resulting from staphylococci resistant to the new antibiotics are occurring in hospitals and households.[1-4]

This problem is world-wide and extends to all areas where antibiotics have been extensively used.[1] The concern lies in the fact that a great number of these organisms are relatively resistant *in vitro* to many of the widely used antibiotics and that the infections caused by them respond poorly to treatment with these drugs and are the cause of an increasing number of deaths.[1]

It is fortunate, therefore, that therapeutic research continues to yield new and better antibacterial drugs. There are many new chemotherapeutic agents which are valuable in superficial infections of the skin which are just as effective as the antibiotics and are no more sensitizing.[4] Their real value, however, lies in the fact that their use avoids the development of organism resistance to the more commonly used antibiotics which may be required at some time in more severe systemic infections.[5]

Internal medication and environmental control are extremely important in the treatment of cutaneous diseases, but the use of effective agents applied directly and repeatedly to the skin lesion itself still constitutes one of the most valuable means of therapy.[6,7] Topical agents for use in skin disease must have a wide-range antibacterial effect and a low potential for producing resistant bacteria, and should cause no primary irritation or sensitization.

On this basis, Triburon,* a bisquaternary compound, has been found to be an effective topical agent in the treatment of cutaneous infections. The method of local subcutaneous infection of mice showed Triburon to be effective against strains of Streptococcus pyogenes, Staphylococcus aureus, and E. coli.[8] In clinical studies involving a variety of dermatoses and infective organisms, Triburon was effective in more than 80 per cent of the cases treated.[9,10] These reports also show that Triburon causes no primary irritation or sensitization. No evidence of irritation or sensitization was encountered in a series of 113 patients who were treated with Triburon for various bacterial infections of the skin, and in 100 patients studied with the use of the covered patch technique, the drug was not a primary irritant.[9,10]

In this study, Triburon and Triburon with

*Trademark for triclobisonium chloride, Hoffmann-La Roche Inc., Nutley, New Jersey

hydrocortisone were used in the treatment of a variety of skin infections.

Methods and Materials

The study comprised 111 patients, ranging in age from 6 weeks to 35 years, who had a variety of dermatoses and bacterial infections. They were divided into two groups according to the therapeutic agent employed, Group I receiving plain Triburon and Group II, Triburon with hydrocortisone.

The diagnosic categories, summarized in Tables I and II, included a wide variety of dermatoses such as folliculitis, seborrheic dermatitis, infectious eczematoid dermatitis, eczema, impetigo, furunculosis and others. The duration of the ailment varied from one day to 20 years and previous treatment consisted of hexachlorophene, calamine, gentian violet, x-ray, neomycin-hydrocortisone, penicillin and various other ointments and lotions with anti-inflammatory and antibacterial properties. Some patients had no previous treatment.

Triburon was applied to the affected area, in most cases three times a day. In Group I, concurrent therapy included Burow's solution in eight cases, Madribon®, and triacetyl oleandomycin suspension. Warm soapy washes were given in two cases, and in three others, hot packs and warm soaks were applied with the Triburon. The duration of treatment varied from 3 days to 102 days and the median duration was 18 days. In Group II, Dalibour solution, talcum dusting and soaks were applied concurrently with Triburon. The median duration was 14 days.

Results were evaluated according to the degree of remission of symptoms and were classified as "cured," "improved," "equivocal," or "unimproved or worse."

TABLE I

Summary of Results with 60 Patients Treated with 0.1 per cent Triburon Ointment

Diagnosis	No. of patients	Response: Cured	Improved	Equivocal	Unimproved or Worse	No Follow Up
Infectious eczematoid dermatitis	9	3	5			1
Folliculitis	7	2	3	1	1	
Eczema	6	2	2		1	1
Furunculosis	6	2	3		1	
Acne	5		4	1		
Infected ulcer	5	1	1	2	1	
Seborrheic dermatitis	3	1	1			1
Psoriasis	3		1		2	
Ecthyma	2	2				
Impetigo	2	2				
Infected wound	2		2			
Miscellaneous	10		6	1	2	1
Total	60	15	28	5	8	4
		77%		23%		

TABLE II

Summary of Results with 51 Patients Treated with 0.1 per cent Triburon plus 0.5 per cent Hydrocortisone

Diagnosis	No. of patients	Response: Cured	Improved	Equivocal	Unimproved or Worse	No Follow Up
Eczema						
Nummular	11	1	5	1	2	2
Contact	4	1	2	1		
Atopic	3		2		1	
Infected	3	1	2			
Miscellaneous	5		4		1	
Infectious eczematoid dermatitis	8	3	4	1		
Infected ulcer	4	1	1		2	
Impetigo	2	2				
Miscellaneous	11	1	8		1	1
Total	51	10	28	3	7	3
		79%		21%		

Results

Group I: Of 60 patients treated with Triburon (plain), four were lost to follow-up; of the remainder, 15 were considered cured, with a complete clearing of symptoms. Twenty-eight of the cases were improved, with up to 80 to 90 per cent remission in several cases. Five patients did not respond to treatment (listed as equivocal), and eight patients were unimproved or worse. Thus, the medication was effective in 43 (77 per cent) and ineffective in 13 (23 per cent). One patient, a 42-year-old man, had multiple furuncles on the left arm which had persisted for one month. Although he did not respond to previous treatment with penicillin, Triburon therapy resulted in complete clearing of his condition within 11 days. Similarly, infectious eczematoid dermatitis of four months' duration in a 1 and 1/2-year-old infant was completely cleared after only seven days of treatment with the drug.

Group II: There was no follow-up in three of the 51 patients treated with Triburon-HC; of the remaining 48, 10 patients were completely cured and 28 showed improvement. Only in three cases was effectiveness questionable, and seven were unimproved or worse. The drug was, therefore, effective in 38 (79 per cent) and not in 10 (21 per cent). One 3-year-old patient in this group had crusted impetigo on the face and arms for one week. Prior treatment with zinc oxide was ineffective, but Triburon completely cleared the condition in seven days.

Of 111 patients in this study, only two showed adverse reactions to the use of Triburon. One patient had a burning sensation at the site of application and the other had a generalized mild erythema with pruritus.

Case Histories

A 3-YEAR-OLD BOY, with a preceding history of eczema for six months, had a superimposed impetigo on the face and forearms. The condition was present for one week prior to his visit to the clinic. He had a crusted, purulent dermatitis on the entire right side of the face and on the right and left antecubital areas. Calamine and pHisoHex® were unsuccessful in previous treatment. The patient was instructed to use warm soap washes followed by application of Triburon three times daily. After three days of treatment, there was 50 per cent improvement with less crusting of the eczematous areas, and after ten days there was only slight erythema. The condition was completely clear after 16 days and there were no side effects from the use of the drug.

A 7-YEAR-OLD BOY had a generalized infectious eczematoid dermatitis on the legs and forearms. The condition had persisted for three months and previous treatment with cortisone tablets and ointment was unsuccessful. He was instructed to apply Triburon plus hydrocortisone three times a day to the affected areas. After seven days of treatment, there was no active vesicular eczema and the patches were dry and scaling. After 13 days, the condition was completely cleared and there were no side effects from the use of Triburon.

A 67-YEAR-OLD WOMAN had an infected varicose ulcer on her right leg, of two years' duration. The ulcer was surrounded by scaly, superficial infection which was treated with Triburon following wet soaks three times a day. In seven days there was 50 per cent improvement and in 13 days the infection was cleared and the patient was considered "cured." There were no side effects from the use of Triburon.

AN 8-YEAR-OLD BOY with infectious eczematoid dermatitis had a weepy, infected eczema on the toes of both feet for a period of two weeks. Previous treatment with penicillin and soaks proved ineffective. The patient was instructed to apply Triburon-HC following warm soaks of the infected area. Within five days of the initial treatment there was 75 per cent improvement and in eight days the condition was completely cured. There were no side effects from the use of Triburon.

A 20-MONTH-OLD FEMALE had infected eczema of the scalp for one week. She had a crusted, oozing and pustular eczema and had no previous treatment. Triburon-HC was applied three times a day, and within seven days the condition was completely clear. There were no side effects from the use of the drug.

Summary

One hundred and eleven patients with a variety of dermatoses and bacterial infections of the skin were treated with either Triburon ointment (Group I) or Triburon plus hydrocortisone (Group II).

Triburon was applied to the affected area in most cases three times a day and the approximate median duration of treatment was 18 days in Group I and 14 in Group II.

In the group using Triburon ointment plain, 15 were considered cured, 28 were improved, five were equivocal, and eight were unimproved or worse. There was no follow-up in four cases.

In Group II, 10 cases were completely cured, 28 showed improvement, three patients remained equivocal and seven were unimproved or worse. There was no follow-up in three cases.

There were only two side effects in 111

patients which supports other clinical data showing that Triburon causes no primary irritation or sensitization.

It is concluded from these results that Triburon is an effective topical agent in the treatment of the dermatoses under study.

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KSMA OFFICERS

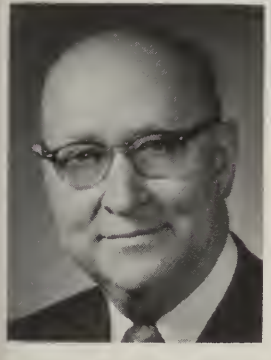
1959

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1960



Irvin Abell, Jr. M.D.
President



David M. Cox, M.D.
Vice President—Central



W. O. Preston, M.D.
Vice President—Eastern



Rex E. Hayes, M.D.
Vice President—Western

President-Elect

Richard G. Elliott, M.D., Lexington

Doctor Elliott, who practices pediatrics in his native Lexington, will be inaugurated as president of the Kentucky State Medical Association during the 1960 Annual Meeting.

Doctor Elliott was born on November 11, 1907, the son of E. Cronly Elliott, D.D.S., and Mary Louise Love Elliott. He attended Lexington public schools, was graduated from the University of Kentucky in 1928, and received his M.D. degree from Vanderbilt School of Medicine in 1932.

After interning at Charity Hospital, New Orleans, he was assistant resident at Children's Hospital, Cincinnati, 1933-1934, and at Children's Hospital, Philadelphia, 1934-1935. He started the practice of pediatrics in Lexington in 1935.

His practice was interrupted by World War II, during which he served in the U.S. Army, in this country and Canada, from January 1941 to October 1945. Entering the service as a first lieutenant in the Medical Corps, he retired as a lieutenant colonel. He is now a colonel in the Medical Corps, USAR, retired.

A Diplomate of the American Board of Pediatrics and member of the American Academy of Pediatrics, Doctor Elliott is also a member of the Fayette County Medical Society, the Kentucky State Medical Association, American Medical Association, Southern Medical Association and Dudley Journal Club.

Active in KSMA, the president-elect served as a delegate to the House of Delegates from 1954-1959, was vice-president (Eastern District) in 1958, councilor of the Tenth District in 1959, and chairman of the Association's Committee on Public Information and Service from 1952-1958. The 1952 president of the Fayette County Medical Society, he served on the society's executive committee from 1953-1955.

Doctor Elliott is chairman of the Lexington-Fayette County Board of Health. Active in civic affairs, he is a member of the Lexington Rotary Club, the First Methodist Church, the Kentucky Civil War Round Table, Pi Kappa Alpha Fraternity and Phi Chi Medical Fraternity.

He is married to the former Virginia O'Rear and they have three sons and one daughter: Edward, 12; Jack, 10; Richard, 7, and Mary Louise, 5.

In electing Doctor Elliott last September, the House of Delegates felt it was living up to the high standards it had met in the past in choosing an outstanding man for the most important office of KSMA president. His deep loyalty to his profession, his willingness to accept responsibility and his efficiency in discharging it, plus his broad experiences as a leader, eminently qualify him to fulfill the highest traditions of the office.

VICE-PRESIDENT, CENTRAL

David M. Cox, M.D., Louisville

Doctor Cox, who limits his practice to gynecology, obstetrics and surgery, has taught gynecology at the University of Louisville School of Medicine since 1930. Born in Hopkins County, he was graduated from the U. of L. Medical College in 1924. He interned and took his residency training at Louisville General Hospital and Lakeside Hospital, Cleveland, and started his practice in Louisville in 1928. During World War II he served as a major and lieutenant colonel in the Medical Corps for 44 months, 18 of which he spent in Europe. He was president of the Jefferson County Medical Society in 1954. Doctor Cox is a member of the Central Association of Obstetricians and Gynecologists and a Fellow of the ACS.

VICE PRESIDENT, EASTERN

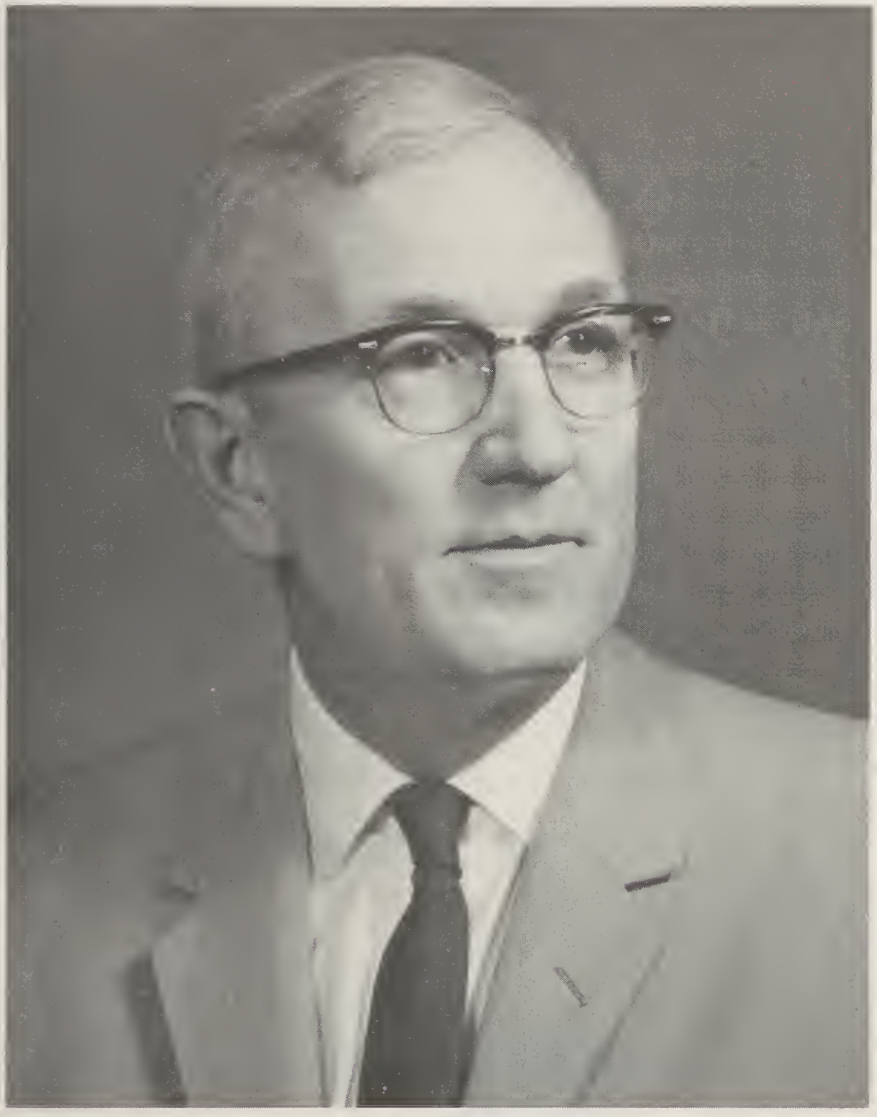
W. O. Preston, M.D., Lexington

A 1936 graduate of Vanderbilt Medical School, Doctor Preston interned at St. Thomas Hospital, Nashville; was assistant resident in surgery at Vanderbilt University Hospital from 1937-39, and was at the Manhattan EENT Hospital in New York City taking training in ophthalmology from 1940-41. After military service in the South Pacific, he returned to the Manhattan EENT Hospital for the practice of ophthalmology. He is a diplomate of the American Board of Otolaryngology and the American Board of Ophthalmology and a member of the American Academy of Ophthalmology and Otolaryngology. A native of Livingston, he is immediate past president of the Fayette County Medical Society.

VICE PRESIDENT, WESTERN

Rex E. Hayes, M.D., Glasgow

Doctor Hayes, a native of Monroe County, was graduated from the University of Louisville School of Medicine in 1933. He served a rotating internship in Louisville General Hospital, followed by two years residency in medicine there. He entered private practic in Glasgow in 1936 and from 1942-46 he was in the U.S. Army Medical Corps. Since his discharge with the rank of major he has been in continuous practice in Glasgow. At present he is serving as chairman of the Barren County Health Department. Doctor Hayes is on the active staff of the T. J. Samson Community Hospital.



Richard E. Elliott

PRESIDENT KENTUCKY STATE MEDICAL ASSOCIATION 1960

KSMA Secretary and Treasurer

SECRETARY

Woodford B. Troutman, M.D., Louisville



A native of Bullitt county, Doctor Troutman has served the Association in several capacities. He was elected to his first full five-year term as secretary in 1958, following two years as interim secretary. He also was KSMA treasurer for 12 years, from 1946 to 1958. Doctor Troutman is active in all levels of the American Heart Association, is a Fellow of the American College of Physicians, and is vice-chairman of the Council on Allied Medical Services. A 1921 graduate of the U. of L. School of Medicine, he interned at McKeesport Hospital in Pennsylvania and Bellevue Hospital in New York. After five years of practice in Louisville he studied in Europe, returning in 1930 to practice cardiology.

TREASURER

Delmas M. Clardy, M.D., Hopkinsville



A KSMA delegate since 1936 (except for Army service) and a District Councilor for six years, Doctor Clardy was elected KSMA treasurer by the House of Delegates in 1958. Doctor Clardy was graduated from the University of Louisville School of Medicine in 1932. He is a past president of the Christian County Medical Society and is currently serving that society as secretary. A general surgeon, he is a Fellow of the American College of Surgeons, a member of the Kentucky Surgical Society, and the Southeastern Surgical Congress. Doctor Clardy, a native of Tennessee, served in the U.S. Army for four years during World War II.

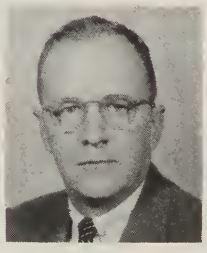
AMA Delegates

W. Vinson Pierce, M.D., Covington



Doctor Pierce was re-elected KSMA delegate to the AMA for his third term at the 1959 Annual Meeting. He was first named delegate in 1955 after serving as alternate delegate. A graduate of the University of Louisville School of Medicine in 1934, he interned at St. Elizabeth Hospital in Covington and General Hospital in Louisville where he also took his residency training in urology. He is a past president of the Kentucky Surgical Society, Kentucky Chapter, American College of Surgeons, and Kentucky Physicians Mutual, Inc. He is chairman of the Advisory Commission to Blue Shield. He is a veteran of World War II.

Robert C. Long, M.D., Louisville



Elected to his first full term in 1958, Doctor Long was originally appointed delegate in December, 1957 to fill the unexpired term of the late Clark Bailey, M.D. Active in medical affairs on the county, as well as the state level, he has served Jefferson County Medical Society in many posts. Doctor Long graduated from the University of Louisville School of Medicine in 1940. Following graduation, he took his internship and part of his residency training at Louisville General Hospital. He completed his residency training at Chicago Lying-In-Hospital. Doctor Long is a past president of the Louisville Obstetrical Society.

KSMA Journal Editors

EDITOR

Sam A. Overstreet, M.D., Louisville

Doctor Overstreet began his service to the Journal of the KSMA as scientific editorial editor. In 1958, he was named editor of the Journal by the Council, following the retirement of the late Guy Aud, M.D. Under his direction, the Journal has made several changes in format including the present blue cover which was first used on the June, 1959, issue. This year in October he and Doctor Pedigo, the associate editor, will be co-hosts at the Third Regional Medical Editors Conference in Lexington which editors from the Southeastern U. S. will attend. Doctor Overstreet is president of the staff of Louisville's new Methodist-Evangelical Hospital which is scheduled to open September 6. He is also chairman of the KSMA Advisory Committee to the Blue Cross Plan.

(A picture of Doctor Overstreet, who is also Speaker of the House, appears on page 932.)

ASSOCIATE EDITOR

George W. Pedigo, Jr., M.D., Louisville



A 1938 graduate of the University of Louisville School of Medicine, Doctor Pedigo completed a term as Vice Speaker of the House last year. He has been associate editor since 1958. An internist, Doctor Pedigo is currently president of the Jefferson County Medical Society. He has served the society previously as secretary and treasurer. Doctor Pedigo was elected to the Board of Directors of the Kentucky Chamber of Commerce and is the first physician to serve in that capacity in the history of that organization. He is a member of the American College of Physicians, a diplomate of the American Board of Internal Medicine, and is immediate past president of the Kentucky Society of Internal Medicine.

New Councilors

FIRST DISTRICT
Hugh L. Houston, M. D., Murray

The 1949 president of KSMA, Doctor Houston has also served the Association as vice-president (western) and councilor. He was born in Calloway county, the son of Dr. Edward B. Houston, one of the founders of the Keys-Houston Clinic-Hospital. He received his A. B. and M. S. degrees from the University of Kentucky and his M. D. degree from Vanderbilt University. He interned in pathology at Vanderbilt Hospital and in surgery at the University of Virginia Medical School, and took postgraduate work in cardiology at Tulane University. He has served as president and secretary of the Calloway County Medical Society, is a Fellow of the American College of Chest Physicians and a member of various other medical organizations.

FOURTH DISTRICT
Dixie E. Snider, M.D., Springfield

Doctor Snider was graduated from the University of Louisville School of Medicine in 1940 and then completed a one-year rotating internship at Louisville General Hospital. He is in general practice in Springfield and also does X-ray work at Mary Immaculate Hospital in Lebanon. From 1942-45 he was in the U. S. Army Medical Corps for which he received the Purple Heart and the Silver Star decorations. For the past six years he has attended the Michigan Postgraduate Course in X-ray.

TENTH DISTRICT
Douglas E. Scott, M.D., Lexington

A native of Ontario, Canada, Doctor Scott has practiced urology in Kentucky since 1933. He received his M. B. degree from the Faculty of Medicine, University of Toronto, his licentiate from the Medical Council of Canada in 1924, and his M. S. degree from the University of Minnesota in 1931. He was certified by the American Board of Urology in 1937. Doctor Scott is chief of urology at Good Samaritan Hospital; associate chief of urology at St. Joseph Hospital, and consultant in urology at U.S.P.H.S. Hospital. He is a member of the AMA, American Urological Association, AUA Southeastern Section and Southern Medical Association.

TWELFTH DISTRICT
T. O. Meredith, M.D., Harrodsburg

Doctor Meredith was graduated from the University of Louisville School of Medicine in 1933, and is in general practice and surgery in Harrodsburg. In 1959 he was KSMA vice-president from the central part of the State. A native of Mercer County, he interned at Norton Memorial Infirmary in Louisville. During World War II he served in North Africa and the European Theater, leaving the service with the rank of major. A past president of the Board of Kentucky Physicians Mutual, he is a member of the board.

FOURTEENTH DISTRICT
William C. Hambley, M. D., Pikeville

A surgeon and instructor in anatomy and physiology at Pikeville College, Doctor Hambley is president of the Pike County Medical Society. He holds a B. S. degree from Notre Dame University and an M. D. and M. Sc. in anatomy from Northwestern. After interning at St. Luke's Hospital, Chicago, he served two years, 1944-46, in the Army Medical Corps with the rank of captain. He took his residency training at VA Hospital, Hines, Ill. Doctor Hambley was instructor in anatomy at Northwestern in 1948-49 and became attending thoracic and vascular surgeon at Methodist Hospital of Kentucky, Pikeville, in 1953. He is a member of the Pikeville City Council.

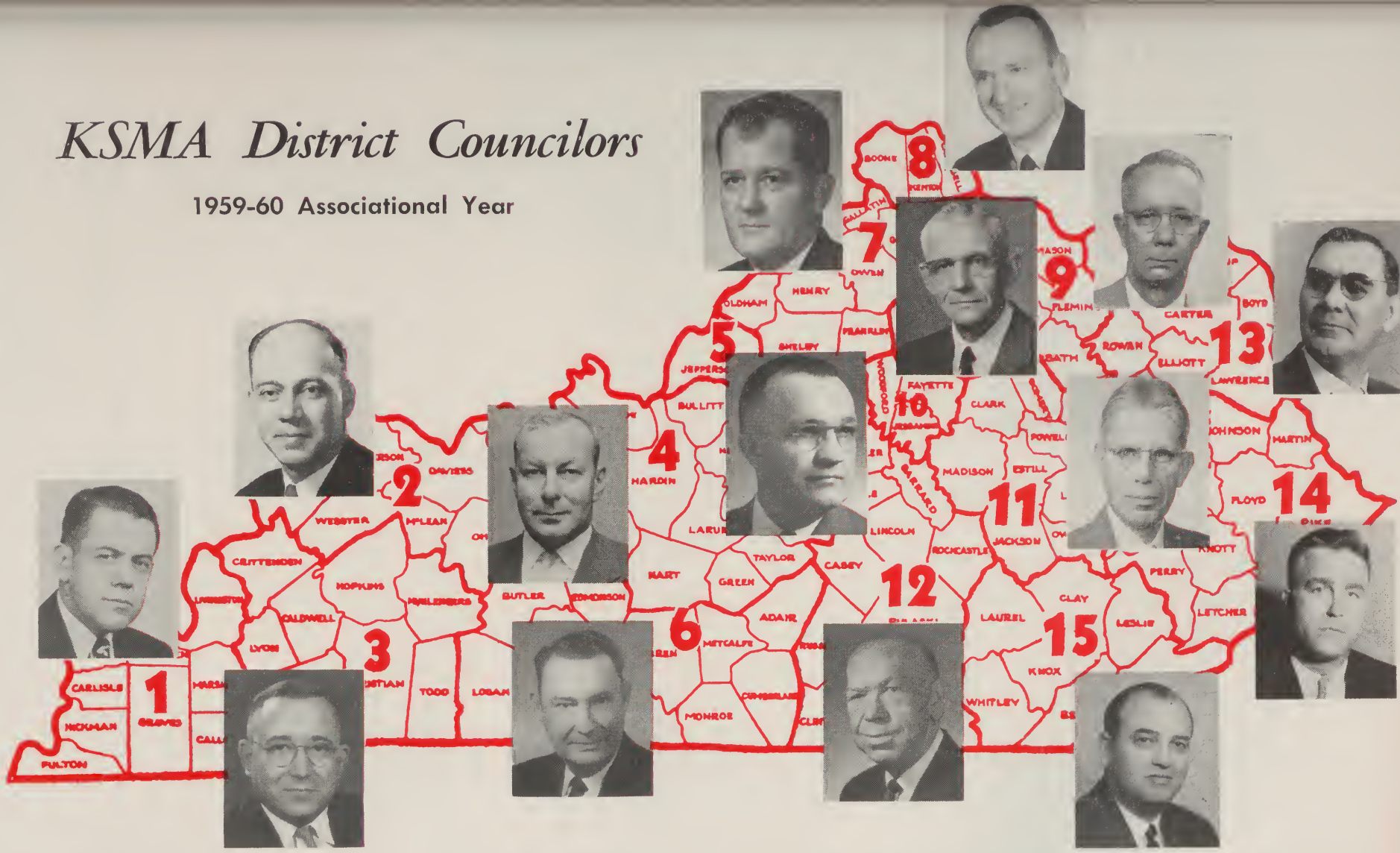
Election Of Councilors

Councilors for six KSMA Districts will be elected by the House of Delegates at its second session on Wednesday, September 21. Nominations will be made at a caucus of the delegates from each district immediately after the first session of the House on September 19. Each committee will report its nominees at the beginning of the second scientific session on Tuesday, September 20. Further nominations may be made from the floor. The six districts are: **Fifth District** (incumbent, Carlisle Morse, M.D., Louisville); **Sixth District** (incumbent, John P. Glenn, M.D., Russellville); **Eighth District** (incumbent, Norman Adair, M.D., Covington); **Tenth District** (In 1958, Richard G. Elliott, M.D., Lexington, was elected for a three-year term expiring in 1961. When he was elevated to office of president-elect in 1959, Douglas E. Scott, M.D., Lexington, was appointed to serve until the 1960 meeting of the House); **Eleventh District** (incumbent, Joe E. Bush, M.D., Mt. Sterling) and **Fifteenth District** (incumbent, Keith P. Smith, M.D., Corbin). All are eligible for re-election. Biographical information on the new councilors elected in 1959 appears above.

See map on next page ⟶

KSMA District Councilors

1959-60 Associational Year



1. HUGH L. HOUSTON
Murroy

2. WALTER O'NAN
Henderson

3. RALPH D. LYNN
Elkton

4. DIXIE E. SNIDER
Springfield

5. CARLISLE MORSE*†
Lousville

6. JOHN P. GLENN*
Russellville

7. WYATT NORVEL
New Costle

8. NORMAN ADAIR*
Covington

9. J. M. STEVENSON*
Brooksville

10. DOUGLAS E. SCOTT
Lexington

11. JOE M. BUSH
Mt. Sterling

12. THOMAS O. MEREDITH
Horrodsburg

13. CHARLES B. JOHNSON
Russell

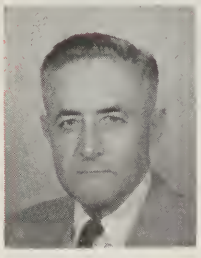
14. WILLIAM C. HAMBLEY
Pikeville

15. KEITH P. SMITH
Corbin

†*Chairman of Council*
**Members of Exec. Committee*

Officers of the KSMA House of Delegates

SPEAKER
Sam A. Overstreet, M.D., Louisville



The KSMA's Centennial president in 1950-51, Doctor Overstreet was elected Speaker of the KSMA House of Delegates at the 1959 session. He is the fourth member to hold the office of Speaker since the reorganization of procedure in the House of Delegates. Presently governor of the Kentucky Chapter, American College of Physicians, he served as president of the Jefferson County Medical Society in 1947 and has served both the state and county groups in various capacities. A graduate of the University of Louisville Medical School in 1923, he is chairman of the KSMA Advisory Committee to Blue Cross.

VICE SPEAKER
Garnett Sweeney, M.D., Liberty



Immediate past chairman of the KSMA Council, Doctor Sweeney was elected vice speaker of the House last year. Before his term as chairman of the Council he had served on the Council's executive committee. He completed his second term as councilor in 1959. A native of Liberty, he has practiced there since 1940. Doctor Sweeney graduated from the University of Louisville School of Medicine in 1939 and interned at Charity Hospital in New Orleans. In 1954, he was president of the Kentucky Chapter, American Academy of General Practice. Doctor Sweeney has served the Association in many capacities.

KSMA Delegates

ADAIR
M. C. Loy, Columbia

ALLEN

ANDERSON
Lewis Wash, Lawrenceburg

BALLARD
Jesse M. Hunt, Jr., Wickliffe

BARREN
W. H. Bryant, Glasgow

BATH
Robin A. Byron, Owingsville

BELL

BOONE
G. L. Rouse, Florence

BOURBON
Richard J. Wever, Paris

BOYD
Guy C. Cunningham, Ashland
Wendell Lyon, Ashland

BOYLE
C. S. Jackson, Danville

BRACKEN
C. A. Marquardt, Augusta

BREATHITT
Robert E. Cornett, Jackson

BRECKINRIDGE
Walter R. Morris, Cloverport

BULLITT
Bruce Hamilton, Shepherdsville

BUTLER
D. G. Miller, Jr., Morgantown

CALDWELL
Frank Giannini, Princeton

CALLOWAY
A. D. Butterworth, Murray

CAMPBELL-KENTON
R. J. Rust, Newport
J. J. Rolf, Covington
W. R. Houston, Elsmere
C. W. Kumpe, Covington
J. H. Humpert, South Ft. Mitchell
D. H. Frickman, Newport

CARLISLE
John T. O'Neill, Arlington

CARROLL
H. Carl Boylen, Carrollton

CARTER
J. Watts Stovall, Grayson

CASEY

CHRISTIAN
H. B. Stone, Hopkinsville

CLARK

CLAY
W. E. Becknell, Manchester

CLINTON
Ernest A. Barnes, Albany

CRITTENDEN
R. M. Brandon, Marion

CUMBERLAND
Joseph Schickel, Burkesville

DAVIESS
L. P. Moore, Owensboro
John S. Oldham, Owensboro
Hays Threlkel, Owensboro

EDMONSON

ELLIOTT
John F. Greene, Sandy Hook

ESTILL
S. G. Marcum, Irvine

FAYETTE
N. L. Bosworth, Lexington
M. C. Darnell, Lexington
Robert Warfield, Lexington
E. C. Strode, Lexington
R. D. Shepard, Lexington
Carl H. Fortune, Lexington
Maurice Kaufmann, Lexington
R. M. Slabaugh, Lexington

FLEMING
R. W. Fidler, Flemingsburg

FLOYD
Russell L. Hall, Wheelwright

FRANKLIN
J. B. Clay, Frankfort

FULTON
R. Ward Bushart, Fulton

GALLATIN
George Harris, Warsaw

GARRARD
O. S. Playforth, Lancaster

GRANT
Claude C. Waldrop, Williamstown

GRAVES
Richard Colley, Mayfield

GRAYSON
P. A. O'Neill, Leitchfield

GREEN
Robert Shuffett, Greensburg

GREENUP
C. I. Haeberle, Russell

HANCOCK

HARDIN
Ruel T. Routt, Sonora
Leo C. McCampbell, Elizabethtown

Delegates (continued)

HARLAN
E. M. Howard, Harlan
David McLean Greeley, Harlan

HARRISON
J. P. Wyles, Cynthiana

HART
David Upton, Munfordville

HENDERSON

HENRY
R. L. Houston, Jr., Eminence

HICKMAN
V. A. Jackson, Clinton

HOPKINS
L. C. Trover, Madisonville
F. A. Scott, Madisonville

JACKSON

JEFFERSON
Benjamin D. Boone, Louisville
J. Randolph Buskirk, Louisville
Rudy J. Ellis, Louisville
Thomas V. Gudex, Louisville
Robert L. McClendon, Louisville
Alfred O. Miller, Louisville
F. Albert Olash, Louisville
William E. Oldham, Louisville
Rudolph F. Vogt, Louisville
Everett H. Baker, Louisville
William Buschemeyer, Louisville
Kenneth P. Crawford, Louisville
Nathan I. Handelman, Louisville
Jack K. Hellman, Louisville
Daniel E. Mahaffey, Louisville
Henry W. Post, Louisville
Stanley E. Smith, Louisville
Robert S. Tillett, Louisville
Austin Bloch, Louisville
Charles J. Bisig, Louisville
Harold Eskind, Louisville
David W. Kinnaird, Louisville
Paul Mapother, Louisville
Harry A. Pfingst, Louisville
George A. Sehlinger, Louisville
David H. Thurman, Louisville
Robert L. Woodard, Louisville

JESSAMINE
J. S. Williams, Nicholasville

JOHNSON
James W. Archer, Paintsville

KNOTT
Denzil Barker, Hindman

KNOX
T. R. Davis, Barbourville

LARUE
J. D. Handley, Hodgenville

LAUREL
Boyce Jones, London

LAWRENCE
Forest F. Shely, Louisa

LEE
J. M. Smith, Beattyville

LESLIE

LETCHER
Thurman M. Perry, Jenkins

LEWIS

LINCOLN
H. I. Frisbie, Stanford

LIVINGSTON

LOGAN
C. V. Dodson, Russellville

LYON
J. E. Cotthoff, Kuttawa

McCRACKEN
Leon Higdon, Paducah
Walter Johnson, Paducah
Walker Turner, Paducah

McCREARY

McLEAN
Everett Coleman, Sacramento

MADISON
Hubert C. Jones, Berea
Douglas Jenkins, Richmond

MAGOFFIN

MARION
B. J. Baute, Lebanon

MARSHALL
Joe Miller, Benton

MARTIN

MASON
Claude E. Cummins, Maysville

MEADE
George E. Clark, Brandenburg

MENIFEE
D. L. Graves, Frenchburg

MERCER
Bacon Moore, Harrodsburg

METCALFE
P. D. Hitchcock, Edmonton

MONROE
William R. Bushong, Tompkinsville

MONTGOMERY

MORGAN
Hershell Murray, West Liberty

MUHLENBERG
G. L. Simpson, Greenville

NELSON
J. J. Sonne, Bardstown

NICHOLAS
B. F. Reynolds, Carlisle

OHIO
Oscar Allen, McHenry

OLDHAM

OWEN

OWSLEY
M. B. Gabbard, Booneville

PENDLETON
William M. Townsend, Falmouth

PERRY
C. D. Snyder, Hazard

PIKE
John H. Scott, Jr., Pikeville

POWELL

PULASKI
Barton L. Ramsey, Jr., Somerset

ROBERTSON
Perry Overby, Mt. Olivet

ROCKCASTLE
George H. Griffith, Mt. Vernon

ROWAN

RUSSELL
Charles E. Peck, Russell Springs

SCOTT
C. R. Lewis, Georgetown

SHELBY
Robert Hamm, Shelbyville

SIMPSON
L. F. Beasley, Franklin

SPENCER
William K. Skaggs, Taylorsville

TAYLOR
H. F. Chambers, Campbellsville

TODD
J. C. Woodall, Trenton

TRIGG
Elias N. Futrell, Cadiz

TRIMBLE
Carl Cooper, Bedford

UNION

WARREN
Harold Keen, Bowling Green
Harper Wright, Bowling Green

WASHINGTON
Harold B. Simms, Springfield

WAYNE
John W. Simmons, Monticello

WEBSTER

WHITLEY
W. M. Buttermore, Corbin

WOLFE
Paul F. Maddox, Campton

WOODFORD

Visit the Scientific and Technical Exhibits at the Annual Meeting

Reference Committee Activity

At the first meeting of the House of Delegates on September 19, all officers and committee reports and resolutions will be referred to one of seven reference committees by Speaker Sam A. Overstreet, M.D., Louisville. Reference committees will meet at 2 p.m. Tuesday, September 20. All reference committee sessions will be held in **air-conditioned second-floor rooms** of the First Christian Church Annex, conveniently located near Columbia Auditorium. Members of the committees will assemble at 1:45 p.m. for briefing sessions. **Any KSMA member wishing to testify on any resolution is urged to be present at 2 p.m.** Open hearings for each reference committee will last at least an hour to permit all who wish to speak to be heard. Following the open hearings, the committees will go into executive session to study the reports and review the testimony given at the hearings. Recommendations will be made for presentation at the final session of the House in the Brown Hotel Roof Garden on Wednesday night, September 21. The reference committees appointed by Doctor Overstreet to serve during the 1960 session are as follows:

1960 Reference Committee Appointments

REFERENCE COMMITTEE NO. 1

Reports of Officers and Councilors

Carl Fortune, M.D., Lexington, Chairman
Bruce Hamilton, M.D., Shepherdsville
W. R. Houston, M.D., Elsmere
L. P. Moore, M.D., Owensboro
Wendell Lyon, M.D., Ashland

REFERENCE COMMITTEE NO. 2

Reports on Medical Care, Medical Education, Hospitals and Related Subjects.

B. J. Baute, M.D., Lebanon, Chairman
D. L. Graves, M.D., Frenchburg
Thurman Perry, M.D., Jenkins
George A. Sehlinger, M.D., Louisville
Harper Wright, M.D., Bowling Green

REFERENCE COMMITTEE NO. 3

Reports on Legislation and Public Relations

L. C. Trover, M.D., Madisonville, Chairman
Alfred O. Miller, M.D., Louisville
J. D. Handley, M.D., Hodgenville
Ruel T. Routt, M.D., Sonora
William M. Townsend, M.D., Falmouth

REFERENCE COMMITTEE NO. 4

Reports on Miscellaneous Business

Robert Dyer, M.D., Louisville, Chairman
H. F. Chambers, M.D., Campbellsville
C. D. Snyder, M.D., Hazard
Dave H. Thurman, M.D., Louisville
John Sonne, M.D., Bardstown

REFERENCE COMMITTEE NO. 5

Reports on Miscellaneous Business

O. L. Higdon, M.D., Paducah, Chairman
E. C. Strode, M.D., Lexington
R. L. Shuffett, M.D., Greensburg
Philip Begley, M.D., Harlan
Austin Bloch, M.D., Louisville

REFERENCE COMMITTEE NO. 6

Reports on Miscellaneous Business

Carl Cooper, M.D., Bedford, Chairman
R. J. Rust, M.D., Newport
M. C. Loy, M.D., Columbia
D. G. Miller, M.D., Morgantown
N. I. Handelman, M.D., Louisville

REFERENCE COMMITTEE NO. 7

Reports on Miscellaneous Business

Ben Boone, M.D., Louisville, Chairman
V. A. Jackson, M.D., Clinton
Perry Overby, M.D., Mt. Olivet
Elias Futrell, M.D., Cadiz
Douglas Jenkins, M.D., Richmond

CREDENTIALS COMMITTEE

L. F. Beasley, M.D., Franklin
Rudy F. Vogt, M.D., Louisville
C. W. Kumpe, M.D., Covington

ALTERNATES

W. K. Skaggs, M.D., Taylorsville
B. F. Reynolds, M.D., Carlisle
Harold Eskind, M.D., Louisville
Henry W. Post, M.D., Louisville
Maurice Kaufman, M.D., Lexington
H. B. Stone, M.D., Hopkinsville
Guy C. Cunningham, M.D., Ashland
P. A. O'Neill, M.D., Leitchfield
John E. Cotthoff, M.D., Kuttawa

Annual Session High Lights

KSMA Headquarters Sept. 20-22



Columbia Auditorium, 824 S. 4th St., is site of Scientific Sessions and Scientific, Technical Exhibits.

• SCIENTIFIC SESSIONS are scheduled daily on September 20, 21 and 22 at the Columbia Auditorium in Louisville. Outstanding scientific presentations, panel discussions and a transatlantic clinicopathological conference featuring panels from the KSMA and the Bromley Division of the British Medical Association will high light the three-day program.

• THE HOUSE OF DELEGATES, the KSMA's policy-making body, will be in session twice during the Annual Meeting—on Monday, September 19, and Wednesday, September 21. Both sessions will be held in the Brown Hotel Roof Garden and will be called to order at 7 p.m., following registration at 5:30 p.m. and a subscription dinner at 6. Officers for 1960-61 will be elected at the second meeting.

• THIRTEEN SPECIALTY GROUPS, for the second year, will meet on two days instead of one. Six groups have programs set for Tuesday afternoon, September 20, and seven for Thursday morning, September 22, in the air-conditioned Sunday-School rooms of First Christian Church. The split sessions, inaugurated last year, met with the approval of physicians. All KSMA members are welcome to attend these programs.

• PRESIDENT'S LUNCHEON on Wednesday, September 21, will feature an address by John B. Reckless, M.B., Ch. B., from the Duke University Medical Center. A former British physician, he will speak on "The Facts of Life In the Future of American Medicine." Presentation of the KSMA's three top awards will be made at the luncheon.

• LUNCHEON FOR NEW MEMBERS on Tuesday, September 20, at the Brown Hotel will be the second annual event honoring the KSMA's new members. All physicians who have joined the Association since September 1, 1959, are invited to attend.

• ALUMNI REUNIONS, traditional adjunct of the Annual Meeting, are planned this year by members of 8 graduating classes of the University of Louisville School of Medicine, beginning with the 1915 class and including every fifth-year class thereafter except 1920. Separate reunions will take the place of the customary dinner for all alumni. A golden anniversary reunion is also planned by the graduates of 1910, who will sit at a special table at the President's Luncheon and receive special recognition. The other celebrating classes are invited to sit in groups at the luncheon.

Official Call

KSMA Annual Meeting

To the officers and members of the component county societies of the Kentucky State Medical Association.

Meeting Place

The Annual Meeting of the KSMA will convene at the Columbia Auditorium, Louisville, Tuesday, Wednesday, and Thursday, September 20, 21, and 22, 1960. The General Session will be called to order at 9 a.m. Tuesday.

The House of Delegates

The first regular session of the House of Delegates will convene at 7 p.m., Monday, September 19; the second regular session will begin at 7 p.m., Wednesday, September 21. Both sessions will be held in the Roof Garden of the Brown Hotel.

Registration

The registration department will be open in the Roof Garden of the Brown Hotel from 5:30 p.m. to 8 p.m., on Monday, September 19, and Wednesday, September 21. It will be open in the Columbia Auditorium from 8 a.m. to 5 p.m. on Tuesday, September 20; Wednesday, September 21; and Thursday, September 22.

Annual Meeting
Woman's Auxiliary to the KSMA

Tuesday, September 20

Preconvention Board Breakfast, 8:45 a.m., Parlors A, B, and C, Brown Hotel; Formal Opening of the 38th Annual Meeting, 10:30 a.m. South Room, Brown Hotel. Subscription Luncheon, South Room, 12:30 p.m. Coffee honoring distinguished guests, South Room, 3:30 p.m.

Wednesday, September 21

Final Business Session, 9:00 a.m., South Room, Brown Hotel. Subscription Luncheon—Style Show, 1:00 p.m., Terrace Room, Kentucky Hotel.

Thursday, September 22

Post-convention Board Meeting and Subscription Breakfast, 9:00 a.m., South Room, Brown Hotel.

Final Insert Photo

This issue of the Journal is the final Annual Meeting number in which the insert-photograph of the incoming KSMA president will be carried. The decision to discontinue the supplemental page, effective in 1961, was made at a meeting of the Advisory Committee to the Editor last January. It was pointed out that the insert actually is a duplication, since a large photograph of the retiring president appears in each Annual Meeting issue.

Former British Physician Booked For President's Luncheon

A widely known British physician will discuss the future of American medicine as guest speaker for KSMA members and distinguished guests at the annual President's Luncheon in the Crystal Ballroom of the Brown Hotel on Wednesday, September 21.



Dr. Reckless

He is John B. Reckless, M.B., Ch.B., who has been in the residency training program of the Department of Psychiatry at the Duke University Medical Center since coming to this country in 1958.

The speaker will be introduced by KSMA president Irvin S. Abell, Jr., M. D., Louisville.

A native of Staffordshire, England, Doctor Reckless holds degrees of Bachelor of Medicine and Bachelor of Surgery from the University of Birmingham, England. He worked under the British National Health Service in the University Hospital for a year and later engaged in general practice for a time. He served as Deputy Assistant Medical Director with the British Military Division in North West Germany before coming to the U.S.

A feature of the President's Luncheon will be the presentation of KSMA's three awards by KSMA secretary Woodford B. Troutman, M.D., Louisville.

KSMA Awards To Be Presented At President's Luncheon

Presentation of the KSMA's awards for 1960 is planned for Wednesday, September 21, as a feature of the President's Luncheon program in the Crystal Ballroom of the Brown Hotel. KSMA secretary Woodford B. Troutman, M.D., Louisville, will make the presentations.

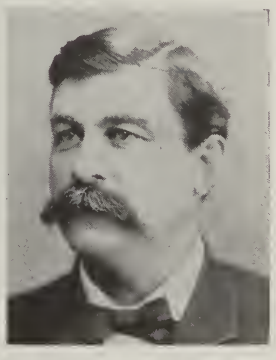
Recipients of the Association's three top honors —Distinguished Service Medal, Outstanding General Practitioner Award and R. Haynes Barr Award— will be selected by the Awards Committee headed by William H. Bizot, M.D., Louisville. Other members are Theodore Davis, M.D., Barbourville; Horace Harrison, M.D., Owensboro; W. M. Savage, M.D., Maysville, and Douglas E. Scott, M.D., Lexington.

Winners of last year's awards were: Francis Massie, M.D., Lexington, Distinguished Service Medal; Leland E. Payton, M.D., Lynch, Outstanding GP, and James R. Sills, M.D., Maysville, the R. Haynes Barr Award given to a layman for outstanding contributions in the field of public health.

KSMA members and guests are urged to wear their badges at all times while attending the 1960 Annual Meeting.

KSMA to Honor 1879 President At 1960 Annual Meeting

The Kentucky State Medical Association will pay tribute to its 1879 president at its 1960 Annual Meeting, which has been designated the Charles H. Todd Memorial Meeting. This follows a custom started in 1935 of honoring a past president or some distinguished Kentucky physician each year.



An interesting biography of Doctor Todd has been written by the KSMA historian, Emmet F. Horine, M.D., Brooks, for the program booklet which will be distributed at the Annual Meeting at Columbia Auditorium, Louisville, September 20-22.

The 1959 meeting honored the Association's 21st president, J. L. Dismukes, who held the office in 1878.

Nominating Committee To Hold Open Meeting Sept. 19

As provided by the KSMA Bylaws, the Nominating Committee has scheduled an open meeting immediately after the close of the first session of the House of Delegates on Monday, September 19. Association members wishing to confer with the committee will be heard at that time.

The committee will make its final recommendations at the beginning of the second scientific session the following day, submitting one or more names for each officer to be elected. The House of Delegates will vote on the nominees at its second session on Wednesday, September 21. Additional nominations may be made from the floor without discussion or comment.

The five-member committee includes: James W. Archer, M.D., Paintsville; Wendell V. Lyon, M.D., Ashland; Daniel E. Mahaffey, M. D., Louisville; Gaithel L. Simpson, M. D., Greenville, and Frank Hays Threlkel, M.D., Owensboro. Any member of the committee will accept suggestions for consideration.

While at the Annual Meeting . . . .

Three Special Phones

will keep you in touch with

Home or Office

You may be easily reached September 19 through September 22, while attending the KSMA annual sessions, if you leave the **special phone numbers** listed below at your home and office, along with your schedule:

JUniper 3-1933 is the special KSMA number at Columbia Auditorium at the KSMA Headquarters Office, where all general scientific sessions will be held.

JUniper 3-0115 is the special number for physicians attending meetings at the First Christian Church. If you plan to attend either of five specialty group sessions or seven reference committee meetings at First Christian Church Tuesday afternoon, September 20—only—call JU 3-0155.

Or, if you plan to attend any of the five specialty group meetings at First Christian Church Thursday morning, September 22, only—call JU 3-0115.

Do not call the First Christian Church number! Call our official number at the Church JU 3-0115.

JUniper 4-1311 (Extension 92) is the special number to be called if you want to be reached either Monday evening, September 19, or Wednesday evening, September 21, while attending the meetings of the KSMA House of Delegates in the Roof Garden of the Brown Hotel.



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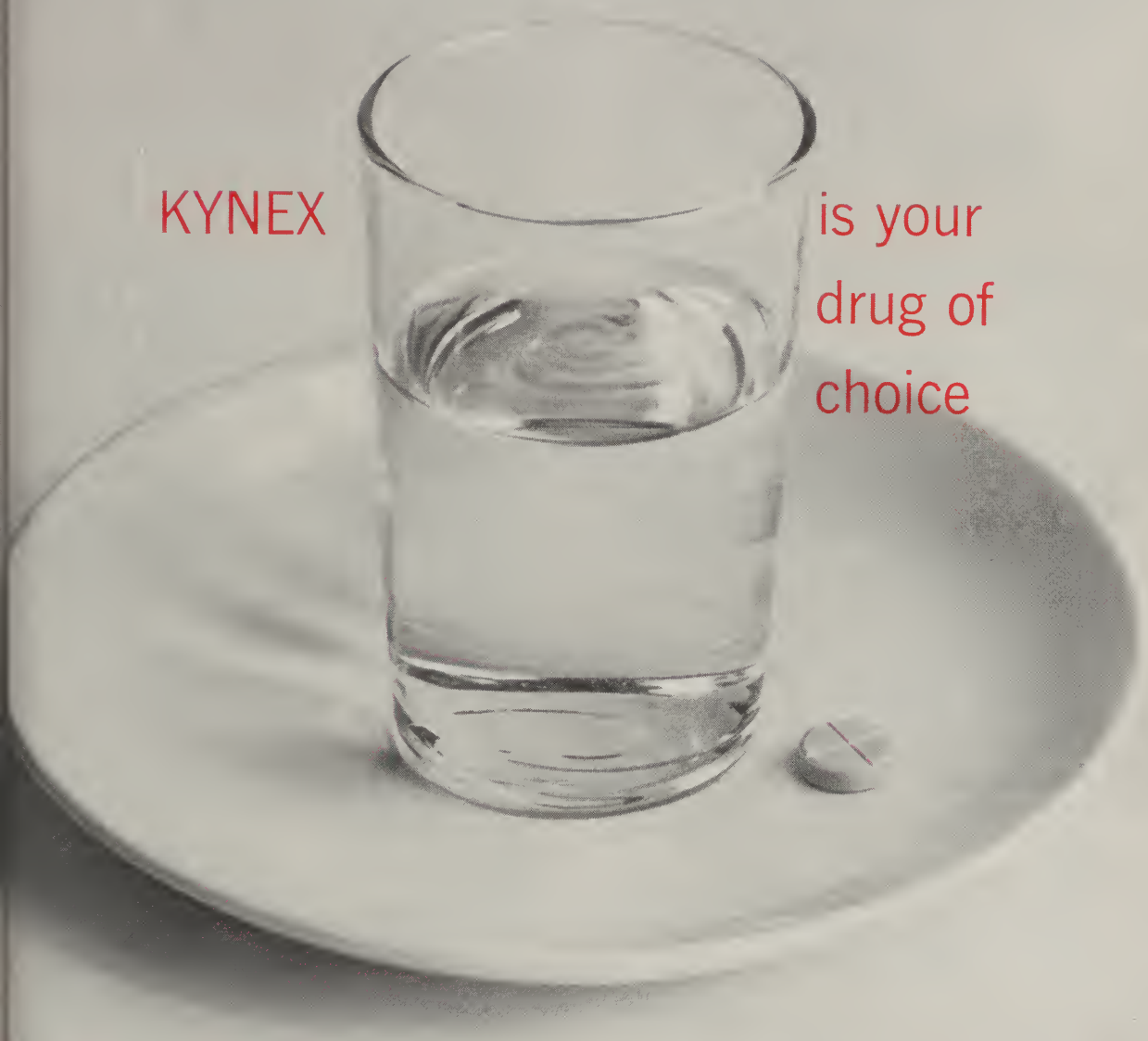
High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.[2] Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.[3]

Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical o KYNEX relative safety, toxicity studies[5] in 22 patients showed TOTAL side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annua 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:105 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.

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Election Of Officers For 1960-61 Slated By House Sept. 21

The annual election of officers of KSMA will take place at the second session of the House of Delegates on Wednesday night, September 21. Officers to be named are:

President-Elect: (Western) one year
Vice-Presidents: (Central) one year
(Eastern) one year
(Western) one year
Delegate to the AMA: two years (Robert C. Long, M.D., Louisville, incumbent)
Alternate Delegate to the AMA: two years (George P. Archer, M.D., Prestonsburg, incumbent)

Orthopaedic Society Announces Second Program Sept. 20

The Kentucky Orthopaedic Society, which is scheduled to hold its specialty session on Tuesday afternoon, September 20, during the 1960 Annual Meeting of KSMA, has arranged a morning program for that day.

Meeting at 10 a.m. at Kosair Crippled Children Hospital, Louisville, the group will hear six scientific presentations, according to the president, William K. Massie, M.D., Lexington. Essayists and their subjects are announced as follows:

Peroneal Spastic Flat Foot—Morgan Colbert, M.D., Louisville.

Legg Perthes Disease—R. P. Kelley, M.D., Atlanta, Ga.

Weight Bearing Treatment of Perthes Disease (Preliminary Report)—D. G. Costigan, M.D.; James M. Riley, Jr., M.D., and Fred E. Coy, Jr., M.D., Louisville.

Osteotomies of the Spine—Scoliosis—K. D. Leatherman, M.D., Louisville.

Athletic Injuries of the Knee—Owen B. Murphy, Jr., M.D., and George M. Gumbert, Jr., M.D., Lexington.

Changing Philosophy of the Doctor in Court—G. W. Holmes, M.D., Winston-Salem, N. C.

Neurosurgeons are especially invited to this program, Doctor Massie pointed out.

Kentucky Pathologists Plan Luncheon On Sept. 22

The Kentucky Society of Pathologists has planned a luncheon at the Pendennis Club, Louisville, at 12 noon on Thursday, September 22, according to the president, John D. Allen, M.D., Louisville.

The guest of honor will be Charles P. Larson, M.D. Tacoma, Wash., the group's guest speaker for the KSMA Annual Meeting. Doctor Larson is immediate past president of the College of American Pathologists.

The luncheon will be followed by a business session which, Doctor Allen said, would adjourn in time for the KSMA general session at 2 p.m. at Columbia Auditorium.

Eight U. L. Classes Plan Reunions During Annual Meeting

Alumni reunions, which each September provide KSMA members an opportunity for fellowship with former classmates, are planned by eight graduating classes of the University of Louisville School of Medicine, as part of the Annual Meeting activities. Separate affairs are being arranged, instead of the customary dinner.

Meeting this year are the fifth-year classes beginning with 1915. The only exception is the class of 1920, which was small and has few members in the state, according to Les Shively, director of alumni relations at the University.

Special recognition of the class of 1910, which marks its golden anniversary, will be made at the President's Luncheon in the Crystal Ballroom of the Brown Hotel on Wednesday, September 21. A special table will be provided for the members, it was announced by Irvin Abell, Jr., Louisville, KSMA president.

The alumni classes holding reunions are also invited to sit at special tables at the President's Luncheon.

For further information about the reunion of your class, contact your chairman:

1915—Henry Reeder, M.D., 140 High Street, Jeffersonville, Ind., and Karl Winter, M.D., Heyburn Building, Louisville 2, co-chairman.

1925—Everett Baker, M.D., 1207 Summit Avenue, Louisville.

1930—Marion F. Beard, M.D., Francis Building, Louisville 2.

1935—McDaniel Ewing, M.D., Heyburn Building, Louisville 2.

1940—George Sehlinger, M.D., Fincastle Building, Louisville 2; Medical Arts Building, Louisville 17.

1945—Robert Noland, M.D., 1974-A Douglas Boulevard, Louisville.

1950—Hoyt Gardner, M.D., Heyburn Building, Louisville 2.

1955—William Gillespie, M.D., Fincastle Building, Louisville 2.

REGISTRATION

You are asked to register at the Registration Booth in the west end of Columbia Auditorium as soon as you are able. Hours are from 8 a.m. to 5 p.m. (CDST), Tuesday, Wednesday and Thursday, September 20, 21, 22.

Please wear your badges at all times while in the Auditorium.

1960 Annual Meeting Program Summary

The Kentucky State Medical Association

September 19, 20, 21 and 22

Louisville

MONDAY, SEPTEMBER 19

12:30 noon	Council Meeting	Louis XVI Room, Brown Hotel
5:30 p.m.	Registration, House of Delegates	Roof Garden, Brown Hotel
6:00 p.m.	Subscription Dinner—House of Delegates	Roof Garden, Brown Hotel
7:00 p.m.	First Meeting of House of Delegates	Roof Garden, Brown Hotel

TUESDAY, SEPTEMBER 20

8:00 a.m.	Registration	Columbia Auditorium
8:45 a.m.	Opening Ceremonies	Columbia Auditorium
9:00 a.m.	First Scientific Session	Columbia Auditorium
10:30 a.m.	President's Address	Columbia Auditorium
10:45 a.m.	Panel Discussion	Louis XVI Room, Brown Hotel
12:00 noon	Annual Luncheon for New Members	
2:00 p.m.	Specialty Group Sessions (Six specialty groups will meet simultaneously. Any KSMA member may attend any of these meetings. See pages 942-943 in program.)	
	Reference Committee Meetings	First Christian Church Annex

WEDNESDAY, SEPTEMBER 21

9:00 a.m.	Second Session	Columbia Auditorium
11:50 a.m.	President's Luncheon for Distinguished Guests	Ballroom, Brown Hotel
2:00 p.m.	Third Scientific Session	Columbia Auditorium
	Transatlantic Telephone Clinicopathological Conference	
5:00 p.m.	Council Dinner	Louis XVI Room, Brown Hotel
5:30 p.m.	Registration, House of Delegates	Roof Garden, Brown Hotel
6:00 p.m.	Subscription Dinner, House of Delegates	Roof Garden, Brown Hotel
7:00 p.m.	Second Meeting, House of Delegates	Roof Garden, Brown Hotel

THURSDAY, SEPTEMBER 22

9:00 a.m.	Specialty Group Sessions (Seven specialty group programs will be held simultaneously. Any KSMA member may attend any of these meetings. See pages 945-946 in program)	
12:00 noon	Council Luncheon	Parlors A, B, C, Brown Hotel
2:00 p.m.	Fourth Scientific Session	Columbia Auditorium
	Panel, 3:30 to 5	
5:00 p.m.	Adjournment	

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting the Scientific and Technical Exhibits.

(Full Scientific Program starts on page 942)

SCIENTIFIC PROGRAM

Charles H. Todd Memorial Meeting

The Kentucky State Medical Association

Columbia Auditorium, Louisville

TUESDAY, SEPTEMBER 20

Registration

8:45 **Opening of General Session**
Call to Order by the President
Irvin Abell, Jr., M.D., Louisville
Invocation
Dr. E. Wade Weldon, Pastor of Fourth Avenue Methodist Church, Louisville
Welcoming Remarks
George W. Pedigo, M.D., Louisville, President, Jefferson County Medical Society

FIRST SCIENTIFIC SESSION

9:00 **"Conservative Management of Lesions of the Lumbosacral Spine"**
Paul C. Williams, M.D., Dallas, Texas

9:40 **"Hemorrhagic Diseases"**
Irving Schulman, M.D., Chicago, Illinois

10:00 **Visit Exhibits**

10:30 **President's Address**
Irvin Abell, Jr., M.D., Louisville, KSMA President

10:45 **Panel—"The Pulmonary Mycoses"**
Daniel N. Pickar, M.D., Louisville Moderator
Oren A. Beatty, M.D., Louisville
John A. Campbell, M.D., Indianapolis, Ind.
A. B. Dickey, M.D., Madisonville
Michael L. Furcolow, M.D., Kansas City, Kan.
Joseph A. Little, M.D., Louisville

12:15 **Luncheon**

Specialty Group Meetings

Six specialty groups will present scientific programs simultaneously and there will be no general session. Programs will be held either in the First Christian Church or the Columbia Auditorium.

Meetings will start at 2:00 p.m., with 30-minute intermissions to visit exhibits scheduled. KSMA members are free to go from one group to another during the sessions.

Kentucky Society of Anesthesiology

First Christian Church, Room 44

2:00 **"The Effects of Intrathecal Detergents"**
Eugene H. Conner, M.D., Louisville

2:30 **"Correlation of EEG Changes and Blood Chloroform Levels"**
Donald M. Thomas, M.D., Louisville

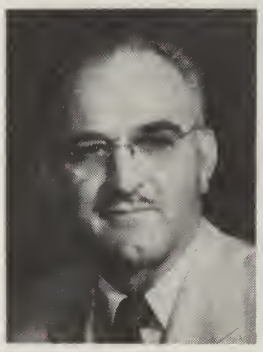
3:00 **Visit Exhibits**

3:30 **"Afibrinogenemia"**
Robert P. Bergner, M.D., and George W. Schafer, M.D., Louisville

4:00 **"Use of Tranquilizers in Surgical Patients"**
E. M. Papper, M.D., New York City

GUEST SPEAKERS

PAUL WILLIAMS, M.D.
Dallas, Texas



Associate professor of orthopaedic surgery at Southwestern Medical College; graduate, University of Michigan with M.D. degree, 1928; intern, Bladgett Memorial Hospital, Grand Rapids, Mich., 1928-29; general surgery, University Hospital, Ann Arbor, 1929-30; junior and senior instructor, orthopaedic staff at the university of Michigan, 1930-33; member, American Academy of Orthopaedic Surgeons, Clinical Orthopaedic Society, Southern Medical Association, Association of Bone and Joint Surgeons and the American Orthopaedic Association.

IRVING SCHULMAN, M.D.
Chicago, Ill.

Professor of pediatrics at Northwestern University Medical School; graduated New York University College of Medicine, 1945; internship, Queens Hospital, New York; residency training in pediatrics, Bellevue Hospital, 1948-50; USPHS postdoctoral Research Fellow in pediatrics, Cornell University Medical College, 1950-52; currently, director of hematology, Children's Memorial Hospital; Diplomate, American Board of Pediatrics, and Fellow, American Academy of Pediatrics; served on the editorial board of several publications, including "Pediatrics."



MICHAEL L. FURCOLOW, M.D.
Kansas City, Kan.



Medical director, Regular Corps, U.S. Public Health Service, and associate clinical professor of medicine, University of Kansas School of Medicine; graduate, Yale University Medical School with M.D. degree, 1934; internship, Bellevue Hospital, New York, and New Haven Hospital, New Haven, Conn., 1934-36; residency in pediatrics, University of Kansas Hospital, 1937-38; commissioned, Regular Corps, U.S. Public Health Service, July 1938; field experience in civilian public health during wartime in North Africa and Sicily under Office of Foreign Relief and UNRRA.

Kentucky Chapter, American College of Chest Physicians

First Christian Church, Choir Room

2:00 "Cultures of Sputa in Bronchial Asthma"
Lloyd Mayer, M.D., Lexington

2:15 "Allergic Manifestations in Non-Tuberculous Chest Diseases"
Armand Cohen, M.D., Louisville

2:30 "The Physiological Consideration of Pulmonary Emphysema"
Armond T. Gordon, M.D., Louisville

3:00 Visit Exhibits

3:30 "The Presentation of Five Cases of the Alveolo-Capillary Block Syndrome"
W. H. Anderson, M.D., Harlan

4:00 "Surgery of Pulmonary Emphysema"
Herbert T. Ransdell, M.D., Louisville

Kentucky Obstetrical and Gynecological Society

Columbia Auditorium, Main Assembly Room

2:00 "Radiation Hazards in Obstetrics"
William F. Mengert, M.D., Chicago, Ill.

2:30 "Cutaneous Gynecology."
Roy L. Kile, M. D., Cincinnati, Ohio

3:00 Visit Exhibits

3:30 Round Table Discussion on Preceding Papers
J. H. Siehl, M.D., Covington
William F. Mengert, M.D.
Roy L. Kile, M.D.

Kentucky Orthopaedic Society

First Christian Church, Room 43

2:00 "The Orthopaedic Approach to Post-Surgical Persistent Pain in Lesion of the Lumbosacral Spine"
Paul Williams, M.D., Dallas

2:15 "Neuro-Surgical Approach and Persistent Sciatica"
R. Glen Spurling, M.D., Louisville

2:30 "Disability Evaluation"
Richard Hudson, M.D., Louisville

2:45 "Rehabilitation of Chronically Disabled Back Patient"
K. Armand Fischer, M.D., Louisville

3:00 Visit Exhibits

3:30 Question and Answer Period
William K. Massie, M.D., Lexington, Moderator

Kentucky Chapter, American Academy of Pediatrics

First Christian Church, Room 46

2:00 "Recent Concepts in the Treatment of Purpura"
Irving Schulman, M.D., Chicago, Ill.

3:00 Visit Exhibits

3:30 "Iron Deficiency in Infancy"
Irving Schulman, M.D., Chicago

Kentucky Radiological Society

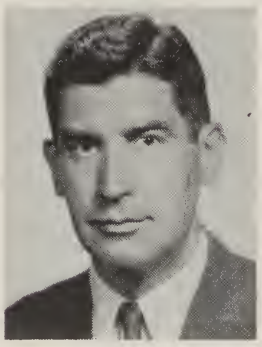
First Christian Church, Room 42

2:00 "Technical Aspects of Image Amplification and Cineradiography"
John A. Campbell, M.D., Indianapolis, Ind.

3:00 Visit Exhibits

3:30 "Clinical Applications of Image Amplification and and Cineradiography"
John A. Campbell, M.D., Indianapolis, Ind.

E. M. PAPPER, M.D.
Riverside, N. Y.



Directar of Department of Anesthesialagy, The Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York City; graduate, New York University with M.D. degree, 1938; Fellaw in medicine, New York University, 1938; intern, 1939, resident, 1940-42 ,Bellevue Hospital; co-founder, Association of University Anesthetists, 1953; consultant, National Research Cauncil, Division of Medical Sciences, 1954; director, American Board af Anesthesialagy, 1955; military service, 1942-46; chief of Section of Anesthesiology, Torney, Dibble and Walter Reed Hospitals; Army Commendation Ribbon.

WILLIAM F. MENGERT, M.D.
Chicago, Ill.

Prafessar and head af the Department af Obstetrics and Gynecalagy, University of Illinois College af Medicine and obstetrician and gynecologist-in-chief, Research and Educational Hospitals; graduate, Johns Hopkins Medical Schaal, 1927; professor and chairman, Department of Obstetrics and Gynecology, Southwestern Medical Schaal of University af Texas, and chairman, Department of Obsterics and Gynecology, Parkland Memarial Hospital, 1943-55; president, Caunsil af American Association af Obstetricians and Gynecalagists, 1958 to date; president, American Callege of Obstetricians and Gynecalagists 1954-55.



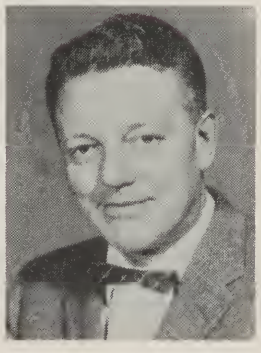
A. C. FURSTENBERG, M.D.
Ann Arbor, Mich.



Prafessor of otalaryngalagy and dean at the University af Michigan; graduated University af Michigan with M.D. degree, 1915; interned and taak residency training at the University of Michigan; certified in otolaryngology in 1925, member, American Academy of Ophthalmalagy and Otalaryngalagy, American Laryngological Assaciation, the American Laryngalagical, Rhinological and Otological Society; Fellaw, American College of Surgeans. Scientific studies have dealt chiefly with the neurological aspects of the ears, nose and throat.

CHARLES P. LARSON, M.D.
Tacoma, Wash.

Director af laboratories far Tacoma General Hospital and ca-owner af private laboratories in Tacoma; graduated McGill University, Montreal, with M.D. and C.M. degrees, 1936; internship, Pierce County Hospital, Tacama; postgraduate training, University of Michigan and University of Oregon Medical Schaals; certified in pathologic anatomy and clinical and forensic pathalagy by the American Board of Pathology; president of Callege of American pathalagists, 1957-59, and president af International Cangress of Forensic Pathology, 1957-58.



WEDNESDAY, SEPTEMBER 21

SECOND SCIENTIFIC SESSION

COLUMBIA AUDITORIUM

David M. Cox, M.D., Louisville, vice president, (Central District) presiding

SCIENTIFIC PAPERS

9:00 **"Office Gynecology"**
William F. Mengert, M.D., Chicago

9:20 **"The Development of Acidosos After Massive Transfusion"**
E. M. Papper, M.D., New York City

9:40 **"The Diagnosis and Treatment of Meniere's Disease"**
A. C. Furstenberg, M.D., Ann Arbor, Mich.

10:00 **Visit Exhibits**

10:30 **"Facts and Fallacies Regarding Alcohol"**
Charles P. Larson, M.D., Tacoma, Wash.

10:50 **"Teen Age Amenorrhea"**
Nicholas W. Fugo, Ph. D., M.D., Chicago

11:10 **"Peridontia As Related to Medicine"**
R. P. Bowen, D.M.D., Louisville

President's Luncheon

BALLROOM—BROWN HOTEL

11:50 A.M.

Irvin Abell, Jr., M.D., Louisville, presiding

Invocation

Dr. Edwin F. Perry, Pastor, Broadway Baptist Church, Louisville

Recognitions

Irvin Abell, Jr., M.D.

Awards Presentations

Woodford B. Troutman, M.D., Louisville, KSMA Secretary

"The Facts of Life in the Future of American Medicine"

John B. Reckless, M.B., Ch.B., Duke University Medical Center, Durham, N. C.

THIRD SCIENTIFIC SESSION

COLUMBIA AUDITORIUM

William O. Preston, M.D., Lexington, vice president (Eastern District) presiding

SCIENTIFIC PAPERS

2:00 **Transatlantic Telephone Clinicopathological Conference with Bromley Division, British Medical Association**

KENTUCKY PANEL:

Beverly T. Towery, M.D., Louisville, Moderator

John D. Allen, M.D., Louisville

John A. Campbell, M.D., Indianapolis, Ind.

David H. Neustadt, M.D., Louisville

BRITISH PANEL:

K. J. Randall, M.D. M.R.C.S., L.R.C.P., Consultant Pathologist, Orpington & Seven Oaks Hospital Group, Moderator

P. S. G. Campbell, M.R.C.S., L.R.C.P., D.-M.R. Consultant Radiologist, Bromley Group Hospital

C. L. Joiner, M.D., M.R.C.P., Physician, Beckenham Hospital and Guys Hospital, London (late fellow in medicine Pennsylvania Hospital, Philadelphia)

N. Southwell, M.A., M.D., M.R.C.P., M.R.-C.S., Consultant Physician, Orpington & Seven Oaks and Crawley Hospital Medical Specialist, Ministry of Pensions and National Insurance.

3:00 **Visit Exhibits**

BEVERLY TODD TOWERY, M.D.
Louisville, Ky.



Professor and chairman, Department of Medicine, University of Louisville, School of Medicine; graduate, Vanderbilt University School of Medicine, M.D., summa cum laude, 1940; internship, Vanderbilt, 1940-41; resident in pathology, Boston City Hospital, 1941-2; asst. resident physician in medicine, Massachusetts General Hospital, 1946; resident physician in Boston City Hospital, U.S. Army Med. Corps, 1941-5, rank of major; Vanderbilt University Hospital, 1949-56; Associate Professor of Medicine, Vanderbilt, 1954-6; certified, American Board of Internal Medicine, 1950.

JOHN A. CAMPBELL, M.D.
Indianapolis, Ind.

Professor and chairman of the Department of Radiology, Indiana University School of Medicine; director of radialogic services at Indiana Affiliated Hospitals and consultant in radiology at Indianapolis General Hospital and Indianapolis Veterans Hospital; graduate, University of Cincinnati, B.S. degree in 1935 and M.D. degree in 1938; Diplomate, American Board of Radiology, 1941; Fellow, American College of Radiology; member American Roentgen Ray Society, Radiological Society of North America, Association of University Radiologists.



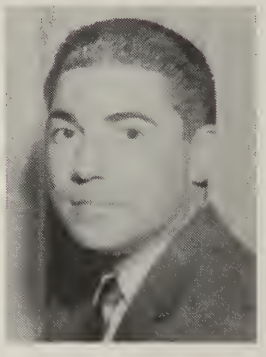
JOHN D. ALLEN, JR., M.D.
Louisville, Ky.



Pathologist and director of laboratories, Kentucky Baptist Hospital, 1951 to present; graduate of Harvard Medical School 1941; intern Cincinnati General Hospital; Fellow in pathology, Bostan City Hospital, 1947-8; Assistant pathologist, St. Anthony Hospital, 1948-9; Trainee, National Cancer Institute, Memorial Hospital for Cancer and Allied Diseases, New York, 1950; Flight Surgeon, USAAF, 1942-6; Diplomate, American Board of Pathology, 1954; member College of American Pathologists; President-elect, Kentucky Society of Pathologists.

DAVID H. NEUSTADT, M.D.
Louisville, Ky.

Instructor in medicine, University of Louisville School of Medicine, and attending Arthritis Clinic, Louisville General Hospital; graduated University of Louisville School of Medicine; internship, Morrisania City Hospital, New York; resident in internal medicine, three years, Lenox Hill Hospital, New York; Clinical Fellow in Rheumatology by grant of National Institute of Arthritis and Metabolic Diseases, 1952; past president, Kentucky Rheumatism Society; secretary, Midwest Rheumatism Association; chairman of Medical and Scientific Committee and past president and chairman of the board of the Kentucky Chapter, Arthritis and Rheumatism Faundation.



3:30 **"Behavior in the Physiological Changes of Aging"**
Ewald W. Busse, M.D., Durham, N.C.
4:00 **"The Relative Merits of Live Attenuated and Formalin Inactivated Poliovirus Vaccines"**
Alexander D. Langmuir, M.D., Atlanta, Ga.
4:30 **Business Meeting, University of Louisville Alumni Association**

THURSDAY, SEPTEMBER 22

SPECIALTY GROUP MEETINGS

Seven specialty groups will meet simultaneously on Thursday morning and there will be no general session. Programs will be held in the First Christian Church, The first Unitarian Church and the Columbia Auditorium.

Sessions will run from 9:00 to 11:50 with a half-hour intermission to visit exhibits at 10:00. All members are welcome to attend any of these sessions.

Kentucky EENT Society

First Christian Church, Room 42

8:30 **Executive Session**
9:00 **"Binaural Hearing Aids—Indications and Limitations"**
William Brown, Ph.D., Louisville
9:30 **(To be Announced)**
Byron Smith, M.D., New York City
10:00 **Visit Exhibits**
10:30 **"Nasal Obstruction—Its Diagnosis and Management"**
A. C. Furstenberg, M.D., Ann Arbor, Mich.
11:00 **"Surgical Techniques and Classifications in Iridectomy"**
Arthur H. Keeney, M.D., Louisville
11:30 **Business Meeting**

Kentucky Chapter, American Academy of General Practice

Columbia Auditorium, Main Assembly Room

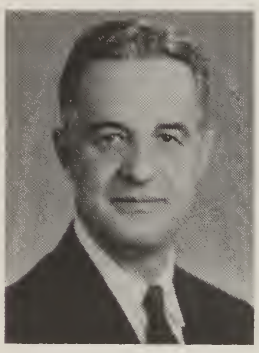
9:00 **"Management of Female Infertility"**
Nicholas W. Fugo, M.D., Chicago
9:30 **"The Clinical Management of Toxemia in Pregnancy"**
William F. Mengert, M.D., Chicago
10:00 **Visit Exhibits**
10:30 **Panel—"Do's and Don'ts of Induction of Labor"**
Benjamin F. Roach, M.D., Midway, Moderator
Nicholas W. Fugo, M.D., Chicago
William F. Mengert, M.D., Chicago
Douglas M. Haynes, M.D., Louisville

Kentucky Society of Pathologists

First Christian Church, Room 44

9:00 **"The Neuropathology of Parkinson's Disease and the Theoretical Neurophysiological Basis of Operative Procedures on the Basal Ganglia"**
R. P. Byrd, M.D., Louisville
9:30 **"A Model Medico-Legal Homicide Investigation"**
Charles P. Larson, M.D., Tacoma, Wash.
10:00 **Visit Exhibits**
10:30 **"Self Healing Squamous Cell Carcinoma of the Skin (Keratoacanthoma)—A Clinical-Histological Review of Fifty Cases"**
H. Davis Chipps, M.D., Lexington
Ullin W. Leavell, M.D., Lexington
11:00 **"Advances in the Diagnosis of the Malabsorption Syndrome"**
E. J. Fadell, M.D., Louisville

NICHOLAS W. FUGO, Ph. D., M.D.
Chicago, Ill.



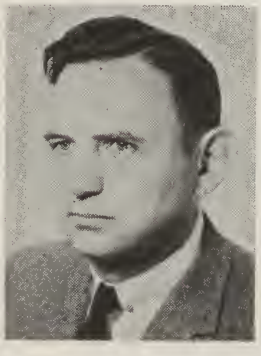
Associate professor, Department of Obstetrics and Gynecology, University of Chicago; M. D. degree 1950, University of Chicago Medical School, Ph.D. degree, 1940, State University of Iowa; Research Associate in Department of Pharmacology, Obstetrics and Gynecology, University of Chicago, 1946-54; Assistant professor, Department of Obstetrics and Gynecology, University of Chicago, 1956; certified, American Boards Obstetrics and Gynecology. Recently appointed professor and chairman of the Department of Obstetrics and Gynecology at the University af West Virginia Medicol School.

R. B. BOWEN, D.M.D.
Louisville, Ky.

Annual exchange speaker from Kentucky Dental Assaciatian; graduated University of Louisville with D.M.D. degree, 1942; postgraduate training, Tufts College Dental School, University of Michigan and University of Pennsylvania; four years military service, periodontia clinic, Randolph Field Base Hospital, Randolph Field, Texas; Diplomate, Americon Board of Periadontology; member, American Academy of Periodontology; post president, Louisville District Dental Society; private practice in Louisville since 1946.



EDWARD W. BUSSE, M.D.
Durham, N. C.



Professor and chairman af the Department of Psychiatry, Duke University Medical Center, ond director of the Center for the Study of Aging at Duke; graduoted Washington University, St. Louis, with M.D. degree, 1942; rototing and neurology internship, St. Louis City Hospital, 1942-43; directar of the Electroencephalograph Laboratory, Colarado Psychopathic Hospitol, ond instructor, University of Colorado, 1946-53; chairman, Committee on Aging, Americon Psychiatric Associatian; Fellow, American Geriatrics Saciety; chairman, Medical Research Committee, White House Canference on Aging.

ALEXANDER D. LANGMUIR, M.D.
Atlanta, Ga.

Chief, Epidemiology Branch, Communicable Disease Center, U.S. Public Health Service, Atlanta, and associate clinical professor of preventive medicine and community health, Emory University School of Medicine; graduate, Cornell University Medical College with M.D. degree, 1935, and Johns Hopkins University School of Public Health with M.P.H. degree, 1940; internship, Boston City Hospital and Harvard Medical Service, 1935-37; Distinguished Service Award, U.S. Department of Health, Education ond Welfare, 1958; member, Advisory Committee to Atomic Bomb Casualty Committee.



Kentucky Chapter, American College of Physicians

First Unitarian Church, Breaux Hall

9:00 "Duodenal Diverticulitis"
D. H. Frickman, M.D., Newport

9:30 "Whipple's Disease; Twelve Cases in One Institution"
Julian M. Ruffin, M.D., Durham, N.C.

10:00 Visit Exhibits

10:30 "An Evaluation of Thyroid Function Tests"
John B. Selby, M.D., Lexington

11:00 "Observations on the Clinical Use of the S.G.O. Transaminase Test"
Carroll H. Robie, M.D., Louisville

Kentucky Psychiatric Association

First Christian Church, Choir Room

9:30 "Report on the Kentucky Commission of Alcoholism"
Louis M. Foltz, M.D., Louisville

10:00 Visit Exhibits

10:30 "Psychological Aspects of Aging"
Ewald W. Busse, M.D., Durham, N.C.

11:30 "Organizational Plans for a Residential Center for Delinquents"
John P. Bell, M.D., Louisville

Kentucky Public Health Physicians

First Christian Church, Room 43

9:00 "Epidemiologic Aspects of Infectious Hepatitis"
Alexander D. Langmuir, M.D., Atlanta, Ga.

9:30 Discussion and Questions

10:00 Visit Exhibits

10:30 "Man Made Disease"
Mitchell R. Zavon, M.D., Cincinnati

11:00 Discussion and Questions

Kentucky Chapter, American College of Surgeons

First Christian Church, Room 46

9:00 "The Neurosurgical Significance of Adult Epilepsy"
Thomas Marshall, M.D., Louisville

9:30 To be announced

10:00 Visit Exhibits

10:30 "An Evaluation of the Whipple Operation for Carcinoma of the Pancreatoduodenal Region"
Jonathan Rhoads, M.D., Philadelphia, Pa.

11:00 (To be Announced)

FOURTH SCIENTIFIC SESSION

COLUMBIA AUDITORIUM

Rex E. Hayes, M.D., Glasgow, vice president (Western District) presiding

2:00 "The Management of Thyroid Nodules and Large Bowel Polyps in the Prevention of Cancer"
Jonathan E. Rhoads, M.D., Philadelphia, Pa.

2:30 "Certain Practical Aspects of the Management of Peptic Ulcer"
Julian M. Ruffin, M.D., Durham, N.C.

3:00 Visit Exhibits

3:30 "Management of the Patient Requiring Surgery"
Panel Discussion:
Rudolf J. Noer, M.D., Louisville, Moderator
E. M. Papper, M.D., New York City
Ewald W. Busse, M.D., Durham, N. C.
Jonathan E. Rhoads, M.D., Philadelphia, Pa.
Julian M. Ruffin, M.D., Durham, N. C.

5:00 Adjournment

JULIAN M. RUFFIN, M.D.
Durham, N. C.



Professor of medicine at Duke University and attending physician and director of Medical Outpatient Clinic at Duke Hospital; graduate, University of Virginia with M.D. degree, 1926; postgraduate training, house officer, Bellevue Hospital, 1926-28; appointments, area consultant in internal medicine and gastroenterology, Veterans Administration, 1946 to date; special consultant to Medical Service, VA, 1959 to date; consultant to Secretary of War in Nutrition, 1942-45; president, American Gastroenterology Association, 1953-54.

JONATHAN E. RHOADS, M.D.
Philadelphia, Pa.

John Rhea Barton Professor of Surgery and director, Harrison Department of Surgical Research, Schools of Medicine, University of Pennsylvania, and chairman, Department of Surgery, Hospital of the University of Pennsylvania; graduate, John Hopkins School of Medicine with M.D. degree, 1932; D.Sc. (Med.) University of Pennsylvania Graduate School of Medicine, 1940; internship, Hospital of the University of Pennsylvania, 1932-34; residency training, Hospital of the University of Pennsylvania; board member and past president of the Philadelphia Division of the American Cancer Society.



KSMA Plans Second Luncheon For New Members Sept. 20

The KSMA's second annual luncheon for its new members is planned for Tuesday, September 20, at the Brown Hotel in Louisville, according to N. L. Bosworth, M. D., Lexington, chairman of the KSMA Committee on Public Information and Service.

The program will include a brief panel discussion on the services offered by KSMA. Doctor Bosworth will act as moderator and the panelists will include: Carl Fortune, M.D., Lexington, speaking on "The Purpose of the KSMA;" Hoyt D. Gardner, M.D., Louisville, discussing "Services the KSMA Renders Its Members," and Garnett Sweeney, M.D., Liberty, talking on "Services the KSMA Offers to the Public."

This new feature of the Annual Meeting, inaugurated last year, proved such a success that the House of Delegates voted to make it an annual event. Not only was the program received with enthusiasm by the new members, but it prompted many inquiries to the KSMA Headquarters Office concerning the work of the Association.

Invitations will be issued this year to physicians who have joined the Association since September 1, 1959. Doctor Bosworth urges all new members to accept.

A list of all new members will appear in the September issue.

Don't fail to visit the Scientific and Technical Exhibits while attending the 1960 Annual Meeting of KSMA.

Scientific Exhibitors

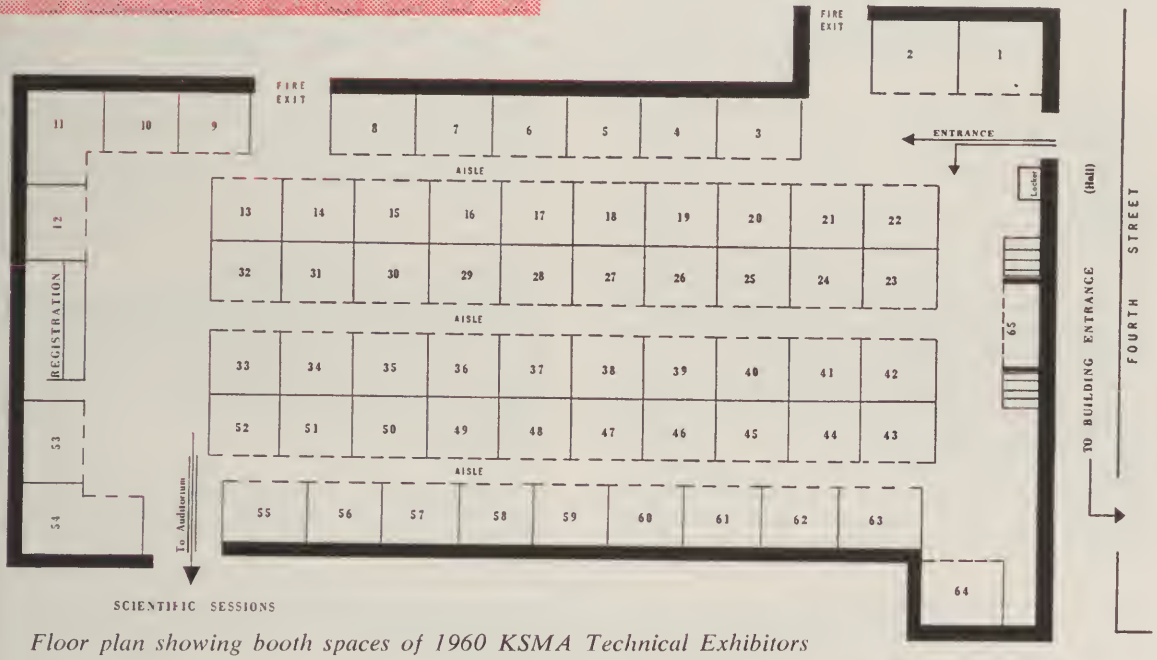
(Located to the right of main entrance)

1. **Comparative Hematologic Response to Iron Fortification of a Milk Formula for Infants**
   Alice March (Garrison), M.D., Pleasant Hill, Mo.
2. **Chronic Low Back Pain—A New Approach to Diagnosis and Treatment**
   John C. Hill, M.D., Louisville, and George S. Hackett, Canton, Ohio

2A. **Old Doc, First Auto Test Driver**
   Illinois State Medical Society, Chicago

3. **Keratoacanthoma (Self-Healing Squamous Cell Carcinoma)**
   Ullin W. Leavell, Jr., M.D., and H. Davis Chipps, M.D., Lexington
4. **An Attempt to Prevent Disruption of Abdominal Wounds**
   Malcolm D. Thompson, M.D., and Blaine Lewis, Jr., M.D., Louisville
5. **Cytology Screening for Uterine Cancer**
   James E. Parker, M.D., and William M. Christopherson, M.D., Louisville
6. **Hip Fractures: Treatment Based on Biomechanical Principles Utilizing a Sliding Nail**
   William K. Massie, M.D.; Kenneth Phillips, M.D., and David Stevens, M.D., Lexington
7. **Hypnosis in General Practice**
   M. E. Bryant, M.D., Colfax, Wash.
8. **Ileostomy**
   David W. Kinnaird, M.D., Louisville
9. **Surgical Reconstruction of the Superior Mesenteric Artery**
   Benjamin B. Jackson, M.D., Louisville
10. **Restorative Arterial Surgery in Individuals with Gangrene of the Lower Extremity**
    J. Herman Mahaffey, M.D., Louisville

Technical Exhibitors



Floor plan showing booth spaces of 1960 KSMA Technical Exhibitors

Abbott Laboratories (13)
A. S. Aloe Company (63)
Ames Company, Inc. (10)
Arnar-Stone Laboratories, Inc. (37)
Ayerst Laboratories (43)
Baker Laboratories, Inc. (60)
Blue Cross Hospital Plan, Inc. (27)
Borcherdt Company (41)
Burroughs Wellcome & Company (55)
Burton, Parson & Company (50)
Carrtone Laboratories, Inc. (6)
Ciba Pharmaceutical Products, Inc. (34)
Coca-Cola Company (64)
Crocker-Fels Company (5)
DePuy Manufacturing Company (40)
The Doho Chemical Corporation (29)
Eaton Laboratories (9)
Geigy Pharmaceuticals (47)
Guild of Prescription Opticians of Ky. (39)
John Hancock Insurance Company (65)
Johnson and Johnson (8)
Kay Surgical, Inc. (11)
Lederle Laboratories (22)
Eli Lilly and Company (23)
J. B. Lippincott Company (59)
McNeill Laboratories, Inc. (58)
J. A. Majors Company (2)
Malkin Instrument Company (48)
Maltbie Laboratories Div. (15)
Mead Johnson & Company (62)
Medco Products Company (46)
Medical Protective Company (19)
Merck Sharp & Dohme (42)
Miller Surgical Co. (35)
William S. Merrell Company (4)
The C. V. Mosby Company (51)
National Insurance Agency (25)
Ortho Pharmaceutical Corp. (57)
Parke, Davis and Company (3)
Pfizer Laboratories (20)
Picker X-Ray Corporation (61)
R. J. Reynolds Tobacco Co. (38)
A. H. Robins Company, Inc. (21)
Roche Laboratories (12)
William H. Rorer, Inc. (45)
Ross Laboratories (26)
Sandoz Pharmaceuticals (31)
Schering Corporation (32)
Julius Schmid, Inc. (36)
Sealy Division, Logan Company (1)
G. D. Searle & Company (54)
Smith, Kline & French Laboratories (14)
Smith, Miller & Patch, Inc. (28)
E. R. Squibb & Sons (52)
The Sutliffe & Case Company (18)
Theodore Tafel (30)
Thermo-Fax Sales Company (17)
United States Tobacco Company (16)
U. S. Vitamin Corporation (53)
The Upjohn Company (7)
Vanpelt and Brown, Inc. (24)
Warner-Chilcott Laboratories (49)
Westwood Pharmaceuticals (44)
Winthrop Laboratories (33)
Max Wocher & Son Company (56)



Site of KSMGA Golf Tourney

The Kentucky State Medical Golf Association will hold its 1960 tournament at the Louisville Country Club, September 20-22, in conjunction with the KSMA's Annual Meeting.

Louisville Country Club Chosen For 1960 Golf Tourney

KSMA golfers will have an opportunity to test their skill on the fairways of the Louisville Country Club during the KSMGA annual golf tourney from September 20-22.

Announcement of this year's tourney, a traditional adjunct to the Annual Meeting, was made by William Wolfe, M. D., chairman of the golf committee. Doctor Wolfe stated that the "host plan" used for the first time last year would be in operation and members of the committee would be present to greet members on their arrival at the Club.

Golf dues are $6 and include the green fee in addition to the dues. In 1959, about 60 members paid golf association dues. This year the permanent prizes to the three top winners will be purchased at the Louisville Country Club pro shop and may be exchanged for anything of like value. These permanent prizes, plus one year's possession of traveling trophies will be awarded to those winning top honors in the low gross, low net and senior championship categories.

Last year top prizes went to Ralph Denham, M. D., Louisville, low gross; Robert McLeod, M. D., Somerset, low net; and T. J. Overstreet, M. D., Lexington, senior championship.

Members of the Associate Committee on KSMA Golf, headed by Doctor Wolfe, include: Harold Baker, M. D., Louisville; Clifton Follis, M. D., Glasgow; Martin Kaplan, M. D., Louisville; Kenton Leatherman, M. D., Louisville; Lanier Lukins, M. D., Louisville; Robert Wooldridge, M. D., Paducah; and James Archer, M. D., Paintsville.

Golfers wishing to play should send the attached application blank to the KSMA headquarters office enclosing the $6 in dues.

CLIP HERE

APPLICATION FOR MEMBERSHIP
KSMA Golf Association

(Please complete and return immediately)

to: KSMA Golf Committee
Kentucky State Medical Association
1169 Eastern Parkway
Louisville 17, Kentucky

Name .....

Street .....

Town .....

Cash enclosed is $6.00 ..... Check, $6.00 .....

During the 1960 annual KSMA Golf Tournament, I would like to play September 20, 21 or 22. (Circle day or dates)

PROGRAM

THIRTY-EIGHTH ANNUAL MEETING WOMAN'S AUXILIARY TO THE KENTUCKY STATE MEDICAL ASSOCIATION

BROWN HOTEL
LOUISVILLE, KENTUCKY
September 20, 21, 22, 1960

Convention Theme: "Provocative Challenge!"

REGISTRATION:
North Bay of Lobby, Brown Hotel
Monday 12 noon to 5 P.M.
Tuesday 8:30 A.M. to 5 P.M.
Wednesday 9:00 A.M. to 12 noon

TUESDAY, SEPTEMBER 20

8:45 A.M.

PARLORS A B C, BROWN HOTEL

Preconvention Board Breakfast (subscription). The Board consists of all state officers, councilors, state committee chairmen, county auxiliary presidents, and three past presidents.

10:30 A.M.

SOUTH ROOM

Formal opening of the 38th Annual Meeting of the Woman's Auxiliary to the Kentucky State Medical Association.

Presiding .....Mrs. Charles B. Johnson
Russell

Invocation .....Mrs. C. Dana Snyder
Hazard
Co-Ordinator For Members-At-Large

Pledge of Allegiance to the Flag ....Mrs. Jess T. Funk
Bowling Green

"I pledge allegiance to the flag of the United States of America and to the Republic for which it stands. One Nation, under God, indivisible, with liberty and justice for all."

Pledge of Loyalty .....Mrs. Jess T. Funk

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

Address of Welcome .....Mrs. Meyer Harrison
Louisville
President—Jefferson County Auxiliary

Response .....Mrs. Hugh Mahaffey
Richmond, First Vice-President

In Memoriam .....Mrs. Daniel L. Bower
Williamsburg—Whitley County

Presentation of Convention Chairmen
Mrs. Morgan R. Colbert
Louisville, Convention Chairman

Presentation of Distinguished Guests

Roll Call .....Mrs. Merle M. Mahr
Madisonville, Secretary

Minutes of the 37th Annual Meeting
Mrs. Merle M. Mahr

Report of the 1960 National Convention
Mrs. Guy Morford
Owensboro, Vice-President

Report of the Councilor of the Woman's Auxiliary to the Southern Medical Association ..Mrs. Robert F. Monroe
Louisville, Councilor from Kentucky

REPORT OF OFFICERS:

Treasurer .....Mrs. R. O. C. Green
Bowling Green

President-Elect & Membership Chairman
Mrs. Earl W. Roles
Prospect

President .....Mrs. Charles B. Johnson

Old Business.

New Business.

Report of the Nominating Committee ..Mrs. Jess T. Funk
Chairman

Election of Nominating Committee for 1960-1961.

Presentation of 1960-1961 Budget ..Mrs. Carlisle Morse
Louisville, Finance Chairman

Report of Registration .....Mrs. Gaithel L. Simpson
Greenville
President—Muhlenberg County

Reports of Chairmen.

12:30 P.M.

SOUTH ROOM

SUBSCRIPTION LUNCHEON

In Honor Of

Mrs. John M. Chenault .....Decatur, Alabama
President, Woman's Auxiliary to the Southern Medical Association

Invocation .....Mrs. Leighton L. Cull
Frankfort
Past President, Franklin Auxiliary

Address .....Mrs. John M. Chenault

Program .....Warren County Auxiliary

2:00 P.M.

SOUTH ROOM

Reports of County Auxiliary Presidents

Program.

Coffee Honoring Distinguished Guests
Pike County - Hostesses

All Physicians' Wives Invited.

WEDNESDAY, SEPTEMBER 21

9:00 A.M.

SOUTH ROOM

Invocation .....Mrs. A. S. Holmes
Elizabethtown
Councilor District IV

Roll Call .....Mrs. Merle M. Mahr

Reading of Minutes .....Mrs. Merle M. Mahr

Announcements .....Mrs. Morgan R. Colbert

Address .....Irvin Abell, Jr., M.D.
Louisville, KSMA President

Address .....Mrs. Harlan English
President-Elect, Woman's Auxiliary to the
American Medical Association

Election of Officers.

Presentation of Distinguished Guests.

Installation of Officers .....Mrs. Harlan English

Inaugural Address .....Mrs. Earl W. Roles

Announcement of Committee Chairmen
Mrs. Earl W. Roles

Courtesy Resolution .....Mrs. J. Vernon Pace
Paducah, McCracken County

Final Report of Registration ..Mrs. Gaithel L. Simpson

Adjournment.

1:00 P.M.

KENTUCKY HOTEL
TERRACE ROOM

SUBSCRIPTION LUNCHEON—STYLE SHOW

In Honor Of:

Mrs. Harlan English, Danville, Illinois
President-Elect, Woman's Auxiliary to the
American Medical Association
Mrs. John M. Chenault, Decatur, Alabama
President, Woman's Auxiliary to the
Southern Medical Association
Past Presidents of the Woman's Auxiliary to the
Kentucky State Medical Association

Invocation .....Mrs. J. Murray Kinsman
Louisville, Rehabilitation Center

Presentation of Distinguished Guests.

Presentation of Past Presidents.

Presentation of Officers.

Presentation of Health Citation Award—
Mrs. J. Andrew Bowen
Louisville
Blue Grass News Editor

Style Show.

Adjournment.

THURSDAY, SEPTEMBER 22

8:45 A. M.

SOUTH ROOM

Post-Convention Board Breakfast and Meeting
(Subscription)

Presiding .....Mrs. Earl W. Roles

Invocation .....Mrs. Carroll P. Price
Harrodsburg
Doctor's Shop Chairman

Meeting of Membership Committee.

STATE CONVENTION COMMITTEE

General Chairman .....Mrs. Morgan R. Colbert
Louisville, Convention Chairman

Registration .....Mrs. Gaithel L. Simpson, Greenville

Luncheon and Flowers ..Mrs. J. Ray Bryant, Louisville

Decorations Co-Chairmen .....Mrs. Charles Bryant
Louisville
Mrs. George Archer, Louisville

Finance .....Mrs. William C. Durham, Louisville

Publicity .....Mrs. Carroll Witten, Louisville

Hostess for Coffee .....Pike County Auxiliary

Hospitality for Out-Of-State Guests:
Mrs. Charles C. Kissinger, Henderson
President, Henderson Auxiliary
Mrs. William L. Woolfolk, Owensboro
Mrs. Robert F. Monroe, Louisville

Tellers .....Mrs. Harry A. Pfingst, Louisville
Past President, Jefferson County Auxiliary
Mrs. Robert M. Sirkle, Lexington
Mrs. Garland Clark, Winchester

Pages .....Mrs. Charles Fisher, Madisonville
Mrs. Lyle Havens, Jeffersonville
Mrs. A. C. Kennedy, Valley Station
Mrs. Samuel M. Adams, London

STATE OFFICERS
1959 - 1960

President .....Mrs. Charles B. Johnson, Russell

President-Elect .....Mrs. Earl W. Roles, Prospect

Vice-President .....Mrs. Hugh Mahaffey, Richmond

Vice-President .....Mrs. C. I. Haeberle, Russell

Vice-President .....Mrs. Guy Morford, Owensboro

Vice-President .....Mrs. Keith Smith, Corbin

Recording Secretary .....Mrs. Merle M. Mahr
Madisonville

Corresponding Secretary .....Mrs. H. B. McWhorter
Ashland

Treasurer .....Mrs. R. O. C. Green, Bowling Green

Parliamentarian ..Mrs. C. Melvin Bernhard, Louisville

ADVISORY COMMITTEE

Clyde C. Sparks, M.D., Ashland
L. O. Toomey, M.D., Bowling Green
Joe M. Bush, M.D., Mt. Sterling

IMMEDIATE PAST PRESIDENTS

Mrs. Charles B. Stacy, Pineville
Mrs. J. Andrew Bowen, Louisville
Mrs. Jess T. Funk, Bowling Green

DISTRICT COUNCILORS

1st—Mrs. R. Ward Bushart, Fulton
2nd—Mrs. Charles C. Kissinger, Henderson
3rd—Mrs. R. E. Davis, South Carrollton
4th—Mrs. A. S. Holmes, Elizabethtown
5th—Mrs. W. Burford Davis, Louisville 7
6th—Mrs. J. Jack Martin, Tompkinsville
7th—Mrs. Joseph Liebman, Frankfort
8th—Mrs. C. Walker Air, Ludlow
9th—Mrs. George E. Estill, Maysville
10th—Mrs. Coleman Johnston, Lexington
11th—Mrs. Robert J. Salisbury, Mt. Sterling
12th—Mrs. Arthur L. Cooper, Somerset
13th—Mrs. E. W. Garred, Catlettsburg
14th—Mrs. Paul B. Hall, Paintsville
15th—Mrs. Garrett Craft, Harlan
Co-Ordinator For Members-At-Large
Mrs. C. Dana Snyder, Hazard

COMMITTEE CHAIRMEN

American Medical Education Foundation:
Mrs. David M. Cox, Louisville
Benevolence ... Mrs. Raymond Sanders, Williamsburg
Bulletin ..... Mrs. Clyde C. Sparks, Ashland
Bylaws ..... Mrs. R. W. Robertson, Paducah
Cancer: Chairman ..... Mrs. William S. Swartz Lexington
Co-Chairman ..... Mrs. William Wharton Lexington
Civil Defense ..... Mrs. B. T. Harris, Lexington
Community Service ..... Mrs. G. B. Froage, Paducah
Doctor's Shop .... Mrs. Carroll P. Price, Harrodsburg
Finance ..... Mrs. Carlisle Morse, Louisville 7
Heart ..... Mrs. Charles Rutledge, Hazard
Historian ..... Mrs. John S. Harter, Louisville
Legislation ..... Mrs. F. H. Hodges, Pikeville
McDowell House .... Mrs. Walker Owens, Mt. Vernon
Mental Health ..... Mrs. Charles B. Stacy, Pineville
Nominations ..... Mrs. Jess T. Funk, Bowling Green
Paramedical Careers Recruitment .. Mrs. John Ashworth Louisville
Past Presidents ..... Mrs. P. E. Blackerby, Louisville
Program ..... Mrs. A. B. Colley, Owensboro
Rehabilitation .... Mrs. J. Murray Kinsman, Louisville
Rural Health .... Mrs. William W. Wainer, Providence
Safety ..... Mrs. Paul F. Rizk, Grayson
Tuberculosis ..... Mrs. Duane Jones, Ashland

PAST PRESIDENTS TO THE WOMAN'S AUXILIARY TO THE KENTUCKY STATE MEDICAL ASSOCIATION

*1923—Mrs. Graham Lawrence, Shelbyville
*1924—Mrs. Graham Lawrence, Shelbyville
*1925—Mrs. Van Albert Stilley, Benton
*1926—Mrs. Van Albert Stilley, Benton
*1927—Mrs. William M. Martin, Harlan
*1928—Mrs. James Thomas Reddick, Paducah
1929—Mrs. Philip E. Blackerby, Louisville
1930—Mrs. E. B. Houston, Murray
*1931—Mrs. George A. Hendon, Louisville
1932—Mrs. Arthur T. McCormack, Louisville
*1933—Mrs. Bartlett K. Menefee, Covington
*1934—Mrs. Joseph I. Greenwell, New Haven
1935—Mrs. Luther Bach, Florence
*1936—Mrs. Ernest Arthur Barnes, Albany
1937—Mrs. Stephen C. McCoy, Louisville
*1938—Mrs. Harlan Usher, Sedalia
1939—Mrs. Reasor T. Layman, Elizabethtown
1940—Mrs. John M. Blades, Butler
*1941—Mrs. John G. South, Frankfort
1942—Mrs. John B. Floyd, Richmond
1943—Mrs. Octavus Dulaney, Louisville
*1944—Mrs. Eleanor Hume Offutt, Frankfort
1945—Mrs. Shelby Carr, Richmond
1946—Mrs. Elmer L. Henderson, Louisville
1947—Mrs. Walker Owens, Mt. Vernon
1948—Mrs. R. Haynes Barr, Owensboro
1949—Mrs. Elbert W. Jackson, Paducah
1950—Mrs. Clark Bailey, Harlan
1951—Mrs. John S. Harter, Louisville
1952—Mrs. David Woolfolk Barrow, Lexington
1953—Mrs. Clyde C. Sparks, Ashland
1954—Mrs. Karl D. Winter, Louisville
1955—Mrs. R. Ward Bushart, Fulton
1956—Mrs. Charles B. Stacy, Pineville
1957—Mrs. J. Andrew Bowen, Louisville
1958—Mrs. Jess T. Funk, Bowling Green

*Deceased

SPECIAL RULES FOR ORDER

1. Officers and delegates are requested to sit in the assigned seats.
2. All persons appearing on the program must be seated on or near the platform when the session opens.
3. Delegates privileges are not transferable.
4. Badges must be worn by the voting body during all general sessions.
5. When addressing the chair, the speaker shall announce her name and that of her auxiliary.
6. Each speaker from the floor shall be limited to two minutes. No speaker may speak more than twice on the same question.
7. Officers giving reports shall be limited to five minutes.
8. No announcements, except those of a vital nature, shall be made from the platform.
9. All visitors are welcome at the general session.
10. All visitors and auxiliary members are requested to register.
11. The proceedings of this convention shall be governed by Robert's Rules of Order, Revised.

BYLAW REVISIONS

The following revisions in the Woman's Auxiliary Bylaws will be discussed at the meeting:

At the Spring Board Meeting of the Woman's Auxiliary to the Kentucky State Medical Association, March 10, 1960, Brown Hotel, Louisville, it was discussed, moved, seconded, and passed to recommend an increase in the allotments of the President and the President-Elect.

As set forth in the Constitution:

Article XII Reimbursement for Expenses

Section 1. The President shall be allowed two hundred dollars per year for necessary expenses.

Revision

Article XII Reimbursement for Expenses

Section 1. The President shall be allocated an amount not less than two hundred dollars per year for necessary expenses. Each year the Finance Chairman shall recommend a specified amount in the budget for the President's allowance.

As set forth in the Constitution:

Article XII Reimbursement for Expenses

Section 2. The President-Elect shall be allowed one hundred dollars per year for necessary expenses.

Revision

Section 2. The President-Elect shall be allocated an amount not less than one-hundred-seventy-five dollars per year for necessary expenses. Each year the Finance Chairman shall recommend a specified amount in the President-Elect's allowance.

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Implantation Of Carcinoma In The Surgical Incision

History

Bryan T. Iglehart, M.D., Resident in Surgery: Patient D.D., a 71-year-old white man, was admitted to the Louisville General Hospital in March of 1955 because of weakness and melena. During the preceding three months he had been treated by a physician for anemia with iron and "shots" but his weakness had persisted, with anorexia and blood in his stools. He had experienced several episodes of nausea and vomiting, but no blood was present in the vomitus.

Pertinent Physical Findings

The patient was a moderately obese, elderly male, not appearing acutely ill. His blood pressure was 160/70; pulse rate 92 and regular; respiration 20; temperature 98. There was no jaundice, but moderate dehydration was noted. The abdomen was slightly distended and hyperperistalsis was thought to be present. There were no palpable abdominal masses. Digital examination of the rectum revealed an enlarged prostate and on withdrawing the finger, soft tarry fecal matter was observed. Sigmoidoscopy revealed tarry feces but no lesion could be demonstrated.

Laboratory and X-Ray Results

Hematocrit, 40 per cent; hemoglobin, 8.5 gm. per cent; white blood cell count, 12,000 per cu. mm., with 77 per cent neutrophiles. Blood urea nitrogen, 38 mg. per cent. The urine contained no abnormal constituents. An x-ray film of the chest revealed no abnormalities. A barium enema was done; a partially obstructing nitraluminal lesion of the ascending colon, 10 cm. above the cecum, was visualized and reported as a carcinoma.

Hospital Course

The patient received a 500 ml. blood transfusion. The bowel was prepared for surgery by means of a low residue diet, saline catharsis and enemas followed by Neomycin and Sulfathalidine.

Operation: A right paramedian incision was made and the patient was found to have a massive cauliflower type lesion about midway between the cecum and the hepatic flexure of the colon. No enlarged nodes were palpated; there were no modules in the liver and no gross evidence of intraabdominal metastasis.

A right hemicolectomy was carried out. The tissue report was adenocarcinoma without lymph node metastasis (Fig.1) The patient made an uneventful recovery and was discharged 12 days postoperatively.

Followup Course

The patient returned to the Louisville General Hospital six weeks following his hemicolectomy, complaining of a hard lump in the mid-portion of the incision. On examination a rather hard fixed mass was found in the mid-portion of the incision. There was no inflammatory reaction. The tumor measured about 5 by 2 cm.

A wide excision of the scar and tumor was executed without difficulty. At operation a second look was had into the abdominal cavity



Figure 1
Photomicrograph of carcinoma of colon.

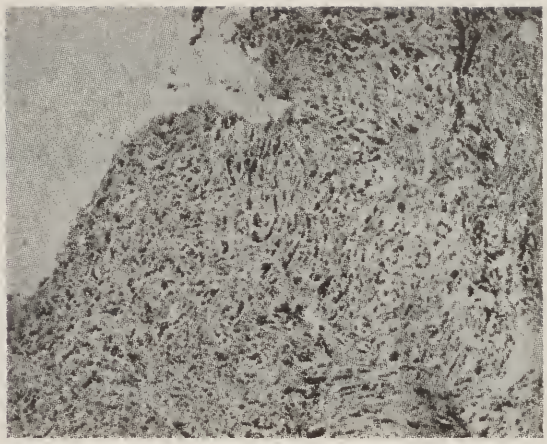


Figure 2
Implantation carcinoma in incision from colon.

with no gross evidence of cancer. The tissue examination revealed adenocarcinoma of the abdominal wall, compatible in origin with the carcinoma of the colon (Fig. 2)

Discussion

D. P. Hall, M.D., Professor of Surgery: The case history presented by Dr. Iglehart is very illuminating and certainly presents a challenge to those doing abdominal surgery. Many of us are acutely aware of the implantation of malignant cells in doing radical mastectomies, but rarely think of implantation in the abdominal incision.

When one considers general peritoneal metastasis and the frequency of implanted carcinoma cells on the serosa in the presence of an active new growth, one must recognize the fertile soil offered by the incision for the implantation of viable cancer cells. Here one finds in the reparative process a closed and sheltered habitat for the cancer cell, with heat, increased blood flow, capillary permeability, great amounts of lymph and a selection of tissues to act as host.

The criteria set forth by De Peyster and Gilchrist, for adequate surgery in malignant lesions, should be remembered: (1) to prevent manipulative venous spread; (2) to prevent implantation; (3) to remove the malignant tumor by en bloc excision with the dependent echelons of lymph node spread.

To lessen the hazard of the implantation of cancer cells in the incision three procedures may be helpful: (1) the use of folded gauze pads to isolate completely both margins of the incision in depth. (2) Quarantine of the malignant area at the earliest stage of the operation. (3) Before closing the incision a change of gloves by the operating team and the use of fresh drapes and instruments.

Harvey C. Hardegree, Jr., M.D., Instructor in Surgery: One point which cannot be emphasized too strongly is early control of the blood supply of the tumor as advocated by Turnbull and others. Also, meticulous attention to hemostasis should be emphasized. The operative field must be kept dry.

There are available canceracidal agents, such as Clorpactin (Monoxychlorosene) which may be used to irrigate wounds and/or placed in instrument basins, and which may prove valuable adjuncts in lessening cancer implants in operative wounds.

Once developed, cancer implants can usually be controlled by excision, irradiation or a combination of the two.

SPECIAL ARTICLES

Report On Actions Of the AMA's House Of Delegates At the 109th Annual Meeting, June 13-17, In Miami Beach*

The growing interest of members of KSMA in the work of the House of Delegates of the American Medical Association was again demonstrated at the Miami meeting June 13-17, as the AMA House considered such important matters as health care for the aged, support of Blue Shield plans, relations with allied health groups, and many other reports and resolutions.

Your delegates, W. Vinson Pierce, M.D., and Robert Long, M.D., and the alternate delegates, George Archer, M.D., and J. Vernon Pace, M.D., were present at all of the meetings of the House of Delegates. Irvin Abell, M.D., KSMA president, and Charles B. Johnson, councilor from the 12th District, were among other members of the KSMA who sat in on the sessions of the House and who helped in covering the various committee hearings. Mr. Joe Sanford, executive secretary of the KSMA; Mr. Bobbie R. Grogan, director of field services; and Mr. Harry Lehman, executive secretary of the Jefferson County Medical Society, likewise rendered invaluable service to the Kentucky delegation in reporting to it concerning the discussion at those reference committee meetings which the delegates and alternates were unable to attend.

One of your delegates, Doctor Pierce, served as a member of the Reference Committee on Medical Education and Hospitals. Included in items considered by this committee were various reports from the Board of Trustees, the guiding principles for relations between physicians and allied professions, approving of hospital residencies, and foreign graduate problems.

The resolution passed by the Council of KSMA commending the AMA on its vigorous and effective stand in resisting passage of the Forand bill was introduced by the senior delegate. It was unanimously adopted and there were expressions of appreciation from F. J. L. Blasingame, AMA executive vice-president, and others.

As the House ended its 1960 annual session, just as the July issue of the Journal went to press, it was not possible to get much material in the organization section of that issue. However, reports of principal elections held by the AMA House in June were either in the July issue or are elsewhere in the organization section of this issue.

Health Care For the Aged

After considering a variety of reports, resolutions and comments on the subject of health care for the aged, the House of delegates adopted the following statement as official policy of the American Medical Association:

"Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state and, only when all these fail, to the federal government, and then only in conjunction with the other levels of government, in the above order. The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept and is not inconsistent with previous actions of the House of Delegates of the American Medical Association."

In connection with an educational program regarding the aged, the House declared that "the American Medical Association increase its educational program regarding employment of those over 65, emphasizing voluntary, gradual and individualized retirement, thereby giving these individuals not only the right to work but the right to live in a free society with dignity and pride."

Pharmaceutical Issues

In the pharmaceutical area the house took two actions—one regarding mail order drug houses and the other involving the development and marketing of pharmaceutical products.

The House agreed with representatives of the pharmacy profession that the unorthodox practice of mail order filling of prescription drugs is not in the best

This is the report of the senior delegate from Kentucky W. Vinson Pierce, M.D., Covington. The Junior delegate, Robert C. Long, M.D., Louisville, makes the report of the Clinical Meeting of the AMA.

interest of the patient, except where unavoidable because of geographic isolation of the patient.

The House also directed the Board of Trustees to request the Council on Drugs and other appropriate Association councils and committees "to study the pharmaceutical field in its relationship to medicine and the public, to correlate available material, and after consultation with the several branches of clinical medicine, clinical research and medical education and other interested groups or agencies, to submit an objective appraisal to the House of Delegates in June, 1961."

The statement pointed out that certain proposals have been made which, if carried out, might impair the future of pharmaceutical research and development, thus retarding the progress of scientific therapy. It also said that the services of the pharmaceutical industry are so vital to the public and to the medical profession that an objective study should be made.

Occupational Health Programs

The House approved a revised statement on the "Scope, Objectives and Functions of Occupational Health Programs," which was originally adopted in June, 1957. The new statement contains no fundamental alterations in AMA policy or ethical relationships, but it adds important new material on the following points:

1. Greater emphasis on the preventative and health maintenance concepts of occupational health programs.

2. A more positive statement of organized medicine's obligation to provide leadership in improving occuptional health services by part-time physicians in small industry.

3. Increased emphasis on rehabilitation of the occupationally ill and injured.

4. Inclusion of the proper use of immunization procedures for employes, as approved by the House in 1959.

5. A more adequate statement on the need for teamwork with lay industrial hygienists in tailoring each occupational health program to the particular employe group involved.

Allied Health Groups

The House approved the final report of the Committee to Study the Relationships of Medicine with Allied Health Professions and Services and commended it as "a monumental work."

To develop physician leadership in promoting cooperative efforts with allied health professions and services, the report suggested the following AMA activities:

1. A general conference should be held with allied scientists in the basic medical sciences and related disciplines for discussion of matters of common concern related to the creation of permanent, cooperative activities.

2. Specific exploratory conferences should be held with members of segments of science allied to a given area of medical practice with the national medical organizations concerned.

3. General and specific conferences should be held with professional and technical assistants on education, recruitment and coordination of contributions.

4. Through meetings and publications, reciprocal exchange of information should be provided between physicians and allied scientists and members of health professions.

5. Effective, continuing liaison should be established between AMA representatives and professional and technical personnel.

Other Actions

In dealing with reports and resolutions on a wide variety of other subjects, the House also:

Strongly reaffirmed its support of the *Blue Shield concept* in voluntary health insurance and approved specific recommendations concerning the AMA-Blue Shield relationships;

Approved a contingent appointment of not more than six months for *foreign medical school graduates* who have been accepted for the September, 1960 qualification examination;

Agreed that the American Medical Association should sponsor a *second National Congress on prepaid health insurance;*

Approved the establishment of a new *"Scientific Achievement Award"* to be given to a non-physician scientist on special occasions for outstanding work;

Approved the following schedule for future *annual meetings*: Atlantic City, 1963; San Francisco, 1964, and New York City, 1965;

Urged individual members of the Association to take a greater interest and more active part in *public affairs* on all levels;

Reaffirmed its opposition to compulsory inclusion of physicians under Title II of the *Social Security* Act and recommended immediate action by all AMA members who agree with that position;

Urged reform of the *federal tax structure* so as to return to the states and their political subdivisions, their traditional revenue sources;

Asked state and county medical societies to make greater use of AMA *recruitment materials* in presenting medicine's story to the nation's high schools;

Commended the Department of Defense and the Air Force for establishing and operating the *Aeromedical Transport Service* and urged that it be maintained at optimum efficiency;

Directed the Board of Trustees to develop *group annuity* and *group disability* insurance programs for Association members.

W. Vinson Pierce, M.D.

EDITORIALS

This Is For Your Patient And You

THE desire to serve our patients better is the motivating force that causes us to spend large amounts of money and time each year in attending medical meetings. We want to "recharge our batteries" as it were, to refresh our knowledge on medical matters, and to learn the latest developments in techniques, procedures, pharmaceuticals and service.

Naturally the kind of work we are doing influences the number of opportunities that we have—men in the more limited specialties may have fewer opportunities. Most of us, however, are interested in not only the latest and best information concerning our own specialty, but we feel we are better physicians if we follow the progress that is being made in the entire field of medicine.

Because the scientific program which is to be presented at the Annual Meeting of the Kentucky State Medical Association, to be held in Louisville September 20-22, is set up for your profit with these very factors in mind, we are able to recommend this program with vigor and enthusiasm.

In addition to four half-day general sessions, featuring panels and illustrated lectures and presenting some of the best medical minds in the country, there will be thirteen half-day specialty group programs. Each of these thirteen groups will have at least one outstanding nationally known guest speaker; a number will have two. As a member of KSMA you are privileged to attend as many of, or a part of as many of these meetings as your interests may lead you.

For the first time at any state medical association, KSMA will present an hour-long Transatlantic Telephone Conference. This will take place Wednesday afternoon, September 21, at 2 p.m. The program will follow the CPC format. Participants will involve four phyicians on the stage at the Columbia Auditorium and four English physicians of the highly regarded Bromley Division of the BMA in the Orpington Hospital.

It may be of interest to some of our members to learn that the KSMA Annual Meeting enjoys one of the highest—if not the highest—percentage of member attendance of any of the states. We have grown to the point where we average almost 50 per cent. This no doubt grows out of the appreciation of our membership for the high caliber of men that participate in it and the worth of the material presented.

Your patients will profit by your attendance at the 1960 meeting, because you'll be able to render a better service as a result of the knowledge you acquire. Moreover, you'll enjoy the lighter side, visiting old friends, renewing and making new acquaintances.

So, plan now to attend the Annual Meeting of KSMA September 20-22. It should be one of our best.

Irvin Abell, Jr., M.D.

An Overlooked Responsibility

EACH physician, whether he be limited to one specialty or embrace the general practice of medicine, is always trying to help his patients remain well. This means that he not only tries to do everything in his power to effect a cure, an improvement in the disease process, but also tries to prevent his patient from developing an illness.

We as physicians usually think in terms of diagnosis, treatment and cure, rather than prevention. When we deal with specific evaluation, prevention comes more to our minds. As a patient presents himself for his routine physical checkup, or when we are examining a patient to determine the cause of illness by way of differential diagnosis, we are more inclined to think in terms of prevention. For instance, the physician looks for small nodes or swellings that could indicate malignancy, and he wants to remove any such growths to prevent extensive disease. There is Diabetes Detection Week to discover early this disease and thus prevent complications. And so with a number of studies we are brought face to face with the idea of prevention.

In our various examinations we could also be aware of and think about the idea of preventing alcoholism. Since alcoholism once developed seems almost impossible to treat and effect some change, prevention would appear to be the best approach. The physician is in a very opportune position to help his patient avoid this dreadful disease. As has been noted before by those interested in alcoholism, histories obtained by the physician recount the patient's use of alcoholic beverages, but frequently only that he "drinks socially," "has an occasional drink." "has a beer or two," etc. In histories we usually require very specific and accurate statements; however, in the case of alcohol there is no effort made to look into the real extent of its use, in spite of the known fact that this is where alcoholism can begin. We would never be satisfied with loose or inaccurate statements in regard to other types of illness.

There is a stage in the individual's drinking pattern where we can point up the idea of prevention. We should determine if there is a change in his drinking habits, an increase in amount or frequency. Are there blackouts? amnesic episodes? Does this person drink in advance of going to a party? Does he have hangovers? Is the "morning after" getting more painful and more frequent? If the patient sees himself in these questions, if he answers in the affirmative to any of them, you have enough evidence to indicate to him that the danger signal exists. You could explain to him that these are symptoms of potential disease, alcoholism. These are forerunners of this disease just as certainly as obesity, excessive food intake, lack of sleep and rest, poor living habits, etc., are of diabetes, heart disease or infection.

I am sure that, if each physician could realize his responsibility in investigating this area of the individual's history, many patients could be helped to avoid the disease of alcoholism. Most patients will consider the advice of their physicians as valuable and will undoubtedly make some effort to follow it. Many who are able to understand the potential danger of alcoholism will discontinue the excessive use of alcohol. It would be the same approach that the physician would use to advise the potential cardiac patient in regard to rest or the potential diabetic in regard to diet; he advises the obese patient about food intake, the allergic patient about the offending allergen, the pregnant patient about weight gain, and so forth. The important factor for the physician to realize is that patients who are aware that they can become alcoholics and that they are on dangerous ground will be able to help themselves. Once they become alcoholics, help is at a minimum.

So let us check as carefully as possible the exact nature of the alcoholic ingestion of each patient as he is examined.

Louis M. Foltz, M.D., Chairman
Kentucky Commission on Alcoholism

ORGANIZATION SECTION

State Conference On Aging Set Sept. 1-2 In Louisville

Kentucky's first state conference on aging, under the auspices of the Citizens Commission on Aging, will be held at the Sheraton Hotel in Louisville on September 1 and 2. Registration is scheduled to begin at 1 p.m. Thursday, September 1.

The Citizens Commission on Aging is composed of 26 members appointed by Governor Combs. KSMA is represented on the body by George Archer, M.D., Prestonsburg; J. Duffy Hancock, M.D., Louisville; Ben Hollis, M.D., Louisville; Robertson O. Joplin, M.D., Louisville, and John Quertermous, M.D., Murray.

Kentucky is one of the states that accepted federal grants for the purpose of studying different facets of aging in the state. One of the prerequisites connected with accepting this money is that a state conference on aging be held prior to October 1960. Recommendations from the state meeting will be forwarded to Washington for use in the White House Conference on Aging scheduled for January 9-12, 1961.

Earl P. Oliver, M. D., Scottsville, chairman of the KSMA Associate Committee on Aging, urges all physicians who are interested in the different fields of aging to plan on being in Louisville and participating in the conference, September 1-2. From preliminary indications it appears there will be considerable time devoted to group discussions.

KSMA Members Urged to Register Before Sept. 10 Deadline

September 10 is the final date for registering to vote in the general election on November 8, KSMA members are reminded by their legislative committee chairmen.

If you did not vote in the last two general elections, you are required to reregister. Also, if you have moved from city to county or from county to city it would be advisable to check with your local registration office about your status as a voter. Regulations vary from place to place.

George Archer, M.D., Prestonsburg, and Wyatt Norvell, M.D., New Castle, respective chairmen of the Legislative Committees for National and State Affairs, urge all KSMA members to make certain that they will have the right to exercise their voting privileges in the coming election.

U. of K. Medical Center Plans Dedication Sept. 23-24

Kentucky medicine will mark a new milestone September 23-24 with the dedication of the new $25,000,000 University of Kentucky Medical Center in Lexington.

In announcing the date, William R. Willard, M.D., vice-president of the Center, said every KSMA member would receive an invitation to the ceremonies as well as detailed information on the program.

Guest speakers will include Rene J. Dubois, M.D., of the Rockefeller Institute, who is scheduled for an address Friday afternoon; Konrad Bloch, Ph. D., chairman of the Department of Chemistry, Harvard University, who will talk Friday night, and Col. Frank B. Rogers, M. C., director of the National Library of Medicine, Washington, who will appear Saturday morning. A reception is planned for Friday night.

Governor Bert Combs and other prominent state officials have been invited to participate in the program.

The full program will be carried in the September issue of the Journal.

Medicine Faces 'Decisive Decade,' New AMA President Says

Where is American medicine headed? What are its objectives?

These were some of the questions put to physicians of the nation by the new AMA president, E. Vincent Askey, M.D., in his inaugural address in Miami Beach on June 14.

The next 10 years will be the "decisive decade," the Los Angeles physician declared. Physicians must prove, he said, that medicine practiced in a free society is the most effective medicine, for the sake of the American public which deserves the best possible medical care.

Doctor Askey pointed to the continuing threat of government intervention into medical practice at a time when the nation is enjoying the best health in its history.

"It is ironic," he asserted, "that at the very moment our capacity for individualized treatment is heralding a revolution in medical care, the pressures mount heavier to force us into adoption of assembly line methods."

AMA Elects U. of K. Dean To Important Council

William R. Willard, M.D., vice-president of the University of Kentucky Medical Center and dean of the U. of K. College of Medicine, has been elected to the important AMA Council on Medical Education and Hospitals. Doctor Willard was nominated by the AMA's Board of Trustees, along with a dean of a large midwestern school, for the vacancy and was elected by the House of Delegates in Miami.



Dr. Willard

The Council on Medical Education and Hospitals each year compiles extensive information about medical schools, hospitals, residency and internship programs, and postgraduate courses. These reports are published in The Journal of the AMA. An abbreviated "Factbook on Medical Education," based on the Council's report, is prepared by the Public Relations Department for speakers and writers on the subject.

Since coming to the University of Kentucky in 1956, Doctor Willard has seen plans for a new medical center and college become a reality. The college is scheduled to open its doors to its inaugural class in September.

Doctor Willard, a native of Seattle, Wash., received his M.D. degree from Yale in 1934, and a Doctor of Public Health degree in 1937. After six years as Deputy State Health Officer for Maryland, he served from 1944 to 1946 as a surgeon with the U.S. Public Health Service, in charge of malaria control in war areas. Later he was acting director of the Public Health and Welfare Department of the U.S. Military Government in Korea. From 1946 to 1951 he held the posts of assistant professor of public health, associate professor and professor at the Yale School of Medicine.

Symposium On Clinical Medicine Set Aug. 21 In Lexington

A Symposium on Clinical Medicine, sponsored by the Kentucky Academy of General Practice and the University of Kentucky Medical Center, is announced for Sunday, August 21, at the Phoenix Hotel, Lexington.

The program, received just as the Journal went to press, is summarized briefly as follows:

Sunday Morning—Welcome, Arnold C. Williams, M.D., Lexington; moderator, Edmund Pellegrino, M.D., U. of K. Medical Center; essayists, William E. Barfield, M.D., Medical College of Georgia, and M. Edwards Davis, M.D., University of Chicago School of Medicine.

Noon—Luncheon for physicians and wives; chairman, John Archer, M.D., Prestonsburg, KAGP president; speaker, Joseph B. Parker, M.D., U. of K. Medical Center.

Afternoon—Moderator, William Winternitz, M.D., U. of K. Medical Center; essayists, John C. Beck, M.D., McGill University Faculty of Medicine, Montreal, Canada, and Francis M. Forster, M.D., University of Wisconsin School of Medicine.

The program is acceptable for six hours of Category 1 Credit by the American Academy of General practice.

U. L. Medical-Dental Unit's Low Bid Is $2,730,000

A low bid of $2,730,000 was submitted June 28 for construction of the new University of Louisville medical-dental building in Louisville's Medical Center. Malan Construction Company of New York City, one of nine bidders, submitted the low figure. The bids are good for 60 days, with final action up to the university's board of trustees.

Fixed equipment is expected to cost an additional $379,600, based on previous bids in this category, according to William J. McGlothlin, U. of L. vice-president. The university has about $2,600,000 available for the work, he pointed out.

About half the cost of the seven-story research unit will be met by the Federal Government. U. of L. will put up a matching amount from the first year's proceeds of a 10-year development campaign. The City of Louisville, as agent for the university, has begun acquiring the site—along the east side of Floyd, from Madison to Walnut.

Orson P. Smith, M.D., To Speak At AMA P-R Institute

Orson P. Smith, M.D., Louisville, has been invited to speak at the Public Relations Institute of the American Medical Association at the Drake Hotel in Chicago, September 1 and 2.

Doctor Smith, who developed and presented the highly successful Jefferson County Medical Society Hobby Show earlier this year, has been asked to describe the program. He expects to have an exhibit to present in conjunction with his talk.

Many veteran observers said that the attendance at the meeting the night of the show was the best in their memory.

License Stolen

The Kentucky medical license issued to Helen Duke Siegrist in 1948 was stolen from her office in Jackson, Mississippi, about July 17-18, 1960. This is called to the attention of all physicians. Any information regarding this should be forwarded to the Kentucky State Board of Health, Frankfort.



MILLIONTH AND FIRST CASES MEET—D. Lane Tynes, president of Blue Cross Hospital Plan, Inc., shows Mrs. James R. Redmond, the millionth hospital case of Blue Cross of Kentucky, a picture of Mrs. James K. Geywitz, right, at the time in 1938 when Mrs. Geywitz, then a year old, was the first Blue Cross hospital case in Kentucky.

Blue Cross Of Kentucky Pays Millionth Hospital Bill

Blue Cross of Kentucky recently paid its millionth hospital bill for care of members, according to D. Lane Tynes, president of Blue Cross Hospital Plan, Inc. He announced the millionth case was that of Mrs. James R. Redmond, Louisville.

The milestone was occasion for an informal meeting at the organizations' home office at 3101 Bardstown Road, Louisville. Guests included Mrs. Redmond and Mrs. James K. Geywitz, Louisville, the first Blue Cross hospital case in Kentucky. On August 23, 1938, when she was a year old, Mrs. Geywitz was hospitalized for pneumonia.

Since that time, Blue Cross, a non-profit organization, has grown to a membership of more than 776,995 Kentuckians and has paid to Kentucky hospitals more than $71,500,000 for care of members.

To date, Blue Cross and Blue Shield have paid more than $3,000 for Mrs. Redmond in hospital and doctor bills.

Illinois Physicians Present $170,890 to AMEF

A check for $170,890—for distribution to the nation's medical schools — was presented by Illinois physicians to the American Medical Education Foundation at the AMA's 109th Annual Meeting in Miami Beach.

The presentation was made June 13 by H. Close Hesseltine, M.D., president of the Illinois State Medical Society, to George F. Lull, M.D., AMEF president, before the AMA House of Delegates. Doctor Hesseltine pointed out that contributions of Illinois physicians to the Foundation in the last three years have averaged more than $200,000 annually, and that since the Foundation's formation nine years ago Illinois has donated more than a million and a half dollars.

Awards of merit were presented to 20 medical groups for their efforts in getting AMEF contributions.

PG Course In Bowling Green Oct. 19-20 Starts Series

"Chronic Disease" is announced as the subject of a two-day postgraduate course to be held October 19-20 in Bowling Green—the first of a series of programs planned for various sections of the state. The courses are designed for the general practitioner as well as the specialist.

The KSMA Postgraduate Medical Education Department is sponsoring the series, in cooperation with the State Department of Health, the University of Louisville, University of Kentucky and American Academy of General Practice.

The program of the Bowling Green meeting, to be held at Ole Fort Restaurant, will be announced in the September issue of the Journal.

KAGP Seminar Draws 66 M.D.'s

Sixty-six physicians were registered for the Cave Area Seminar of the Kentucky Academy of General Practice, held July 7 at Park City. Total attendance was 90.

Essayists for the scientific session were George W. Pedigo, M.D., assistant professor of medicine at the University of Louisville School of Medicine, and Thomas F. Warder, M. D., and A. R. Shands, Jr., M.D., both instructors at Vanderbilt University School of Medicine, Nashville. Elwood Roswey, Park City, was the dinner speaker.

Dr. Stubbs Gets Health-USA Award

Donald H. Stubbs, M. D., Washington, D. C., chairman of the board of the National Association of Blue Shield Plans, was one of three national civic leaders who received the 1960 "Health USA" award sponsored jointly by the Metropolitan Washington Board of Trade and the Medical Society of the District of Columbia. He was presented the honor at a testimonial dinner in Washington on June 1.

Doctor Stubbs is known to KSMA members as a speaker at the 1959 County Society Officers Conference. He is clinical professor of anesthesiology at George Washington University Medical School; head of the Department of Anesthesiology at Doctors Hospital, Washington; senior attending anesthesiologist at Washington Hospital Center, and consulting anesthetist at the Clinical Center, National Institutes of Health.

Health Department Starts Library

The State Department of Health is setting up a new library at its new headquarters in Frankfort. In charge of the work is Miss Charlotte Mugnier, who recently received a master's degree in library science.

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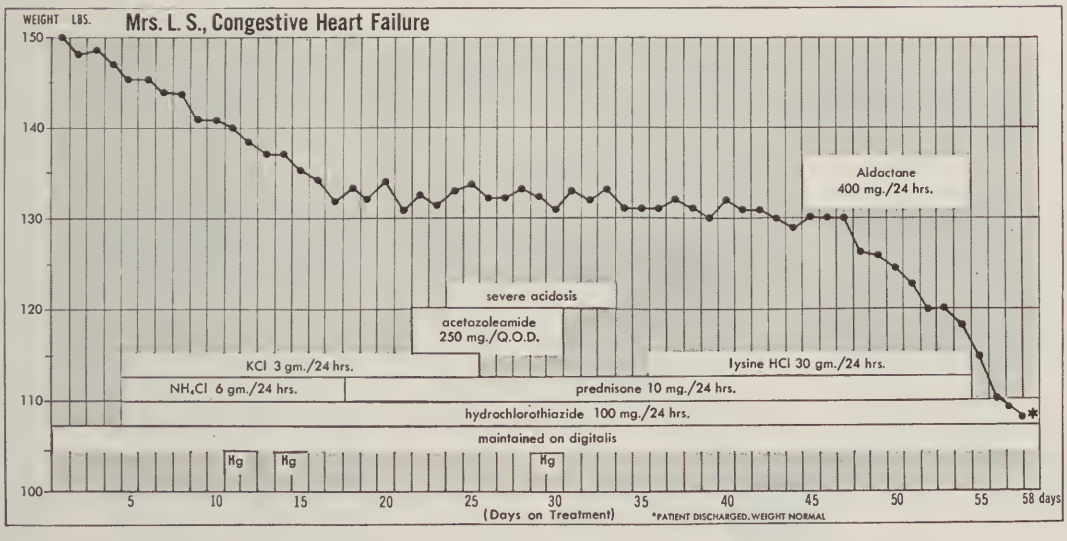
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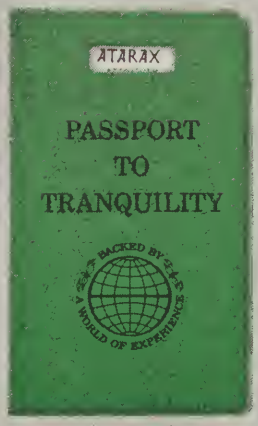
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IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"...Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America **5**:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. **10**:164, 1956. Ayd, F. J., Jr.: California Med. **87**:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. **112**:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"...seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. **7**:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. **8**:1584 (Oct.) 1957. Negri, F.: Minerva med. **48**:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics **11**:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better...and led a more normal life....In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. **169**:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. **64**:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. **50**:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"...especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

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Material Collected Over 25 Years In New Book By Dr. Jelsma

Franklin Jelsma, M.D., Louisville neurosurgeon and assistant professor of neurosurgery at the University of Louisville School of Medicine, is the author of a new book, "Primary Tumors of the Calvaria," which is reviewed on page 972 of this issue of the Journal.



Dr. Jelsma

Clinical material for the monograph was collected over a period of 25 years, and the actual writing required about two years of Doctor Jelsma's spare time. The only book published on the subject, it was written to facilitate handling of cases of tumors of the calvaria by general practitioners, roentgenologists, neurologists and neurosurgeons.

Although this is Doctor Jelsma's first medical book, his name is well known to readers of national medical journals to which he has been contributing since 1928. These papers appeared in the Journal of Neurosurgery, American Journal of Surgery, Journal of the American Medical Association, Journal of the Southern Medical Association, Surgery, Gynecology and Obstetrics, The Southern Surgeon, The Journal of Physiology, the KSMA Journal, and other medical publications.

A native of Guthrie, Okla., Doctor Jelsma received his M.D. degree from the University of Oklahoma 1925, and his M.S. degree from the University of Louisville. After five years postgraduate training, he started practicing in Louisville in 1930.

He is a Diplomate of the Board of Neurosurgeons and a Fellow of the American College of Surgeons. He also holds membership in the American Association for the Surgery of Trauma, the Harvey Cushing Society, Southeastern Surgical Congress, the Southern Medical Association, the Southern Neurosurgical Society, The Academy International of Medicine, and the United States Committee of the World Medical Association, among others.

Interstate Sets 45th Assembly

The Interstate Postgraduate Medical Association of North America has announced the program for its 45th Scientific Assembly to be held October 31-November 3 at the Pittsburgh Hilton Hotel, Pittsburgh. Some 40 medical specialists from all parts of the country are scheduled as essayists. The registration fee is $10.

Interstate, with headquarters in Madison, Wis., has no membership. Its service, according to its medical director, Roy T. Ragatz, is that of providing an annual varied and informative medical postgraduate teaching program for a very nominal fee. The program provides Category I credit for AAGP members.

Two U.L. Aides Get Grants

Research grants to two professors at the University of Louisville School of Medicine have been announced recently. Under a $12,075 grant from the National Institute of Health, Sidney Roston, M.D., instructor in medicine, will study effects of the destruction of Coenzyme A in the human body's metabolic processes. Charles E. Wagner, M.D., assistant professor of anatomy, has been awarded $500 by the Council on Drugs of the American Medical Association for equipment used in the study of how nerves are related to the development of taste organs in unhatched chickens.

Dr. Dodd Retires From U.L. Post

Katherine Dodd, M.D., has retired as professor of pediatrics at the University of Louisville School of Medicine. The 68-year old physician joined the U. of L. staff in 1957 upon her retirement as head of the pediatrics department of the Arkansas Medical School, Little Rock. She was a featured speaker at the 1956 Annual Meeting of KSMA.



Dr. Dodd

The first teacher to hold the title of distinguished professor of pediatrics at the U. of L., Doctor Dodd received the Elizabeth Blackwell award last year and was named "woman physician of the year" by Kentucky physicians in 1958. The Blackwell award is given annually to a woman physician for outstanding contributions to the science, practice or teaching of medicine.

State Gets Nursing Consultant

Miss Elizabeth G. Sullivan, nursing consultant, U.S. Public Health Service, has been assigned to the Kentucky State Department of Health to assist in its Occupational Health Program, according to Russell E. Teague, M. D., Commissioner of Health. She is a native of Winchester, Va.

Miss Sullivan's job will be to promote the health of employed persons throughout Kentucky by working with industrial nurses, plant managers, nursing-school directors, health officers, public health nurses and other staff members of local health departments.

U. L. Alumna Heads Texas Unit

May Owen, M. D., a 1921 graduate of the University of Louisville School of Medicine, took office as the first woman president of the Texas Medical Association at its Annual Meeting in April. Now chief pathologist at Terrell's Laboratories in Forth Worth, she has received many honors and recognition for her research and published papers. She is past president of the Texas Society of Pathologists and was named one of Texas' nine outstanding women in 1951.

Dr. Orr Calls On U. S. Medicine To Improve World Health

A plea for increased medical aid to all parts of the world was made by Louis M. Orr, M.D., in his farewell address as AMA president in Miami Beach on June 13. Improved world health offers a challenge that compels physicians to act, the Orlando physician told the AMA House of Delegates. "Our medical conscience will not let us rest until we do."



Dr. Orr

American medicine, he said, can make a significant contribution by carrying on people-to-people programs—providing medical, clinical and hospital supplies and, when possible, the services of member-physicians.

Speaking from firsthand knowledge gained in his recent travels in the Far East and other parts of the world, Doctor Orr said, "Sickness prevails for the lack of simple medicines. Disabilities go uncorrected for lack of immediate attention. Life expectancy remains at low levels because diseases which modern medicine can control go unchecked."

The retiring president urged physicians to remain vigilant in efforts to defeat old and new Forand-type legislation. He pointed out that medicine favors "the best kind of medical care for the aged" achieved through voluntary, competitive methods, and recommended that the House go on record as favoring: (1) more jobs for the aged; (2) voluntary retirement; (3) a campaign against discrimination because of age, whether it is 40 or 65.

Kentucky Delegation To AMA House Receives Vote Of Praise

The Kentucky delegation at the 1960 annual meeting of the AMA House of Delegates in Miami Beach was commended for its work there in a resolution passed by the Jefferson County Medical Society at its July 8 meeting in Louisville.

The resolution was offered by Michael R. Cronen, M.D., Louisville, a member of the society. It stated:

"That the members of the Jefferson County Medical Society, through its Board of Governors, proudly and most highly commend and express assurance of our esteem and appreciation in recognition of a difficult work willingly and wholeheartedly accomplished beyond duty's usual call, Doctors Vincent Pierce, Robert Long, George Archer and Vernon Pace—as well as their most energetic, effective and faithful assistants, Messrs. Joseph Sanford, Harry A. Lehman and Bob Grogan; also, we wish to highly commend the members of the Kentucky State Medical Association who attend and participate in the business meetings of the AMA and assist the Delegates in their important work."

110 Kentucky Physicians Attend AMA Meeting In Florida

Kentucky physicians known to have registered at the Annual Meeting of the American Medical Association in Miami Beach, June 13-17, totaled 110. The Journal is grateful to Lloyd Prang, director of membership of AMA, for his efforts in providing this information.

W. Vinson Pierce, M.D., Covington, and Robert C. Long, M.D., Louisville, led the Kentucky delegation in the AMA House of Delegates. Other official representatives of the KSMA were Irvin Abell, Jr., M.D., Louisville, KSMA president, and J. Vernon Pace, M.D., Paducah, and George P. Archer, M.D., Prestonsburg, alternate delegates to the AMA.

The complete list of Kentucky physicians in attendance follows:

ASHLAND
Cawood, Walter L.
Schnitzker, W. F.

BEAVER DAM
Bennett, Durrett C.

BURKESVILLE
Kirby, Norman K.
Schickel, Joseph

CAMPTON
Maddox, Paul F.

CARROLLTON
Weaver, Edgar S.

CLINTON
Jackson, V. A.

COVINGTON
Molony, Howard R.
Nutini, Carl J.
Pierce, W. Vinson
Salsbery, Otto H.

FT. CAMPBELL
Freilicn, Michael
Van Osdel, Lewis A.

FT. KNOX
Heslin, William F.

FT. THOMAS
Stevens, Donald M.
Stratman, Edward J.
Tanner, Geo. R.

FULTON
Rudd, Russell R.

HARLAN
Evans, Henry
Anderson, William H.

HOPKINSVILLE
Snowden, Raymond C.

JAMESTOWN
Lawrence, M. M.

LEXINGTON
Berry, John F., Jr.
Floyd, John B.
Floyd, John B., Jr.
Gumbert, G. M., Jr.
Massie, W. K.
McGinnis, K. D.
Morris, R. C.
Preston, W. O.
Ray, Edward H.
Ray, Edward H., Jr.
Redd, Harold, Jr.
Sears, Jane B.
Sears, Kenneth L.

LONDON
Jaunzems, Alfred E.

LOUISVILLE
Abell, Irvin, Jr.
Alcorn, Merritt O., Jr.
Auerbach, S. Pearson
Beatty, Oren A.
Bradshaw, H. W.
Casey, John J.
Collis, Stanley W.
Cronen, M. R.
Dwyer, George, Jr.
Favara, Blaise E.

LOUISVILLE
(Continued) . .

Gardner, Hoyt D.
Hechter, Rebecca
Jain, Mahabir
Jones, Max P.
Keaney, J. M., Jr.
Kommor, Zollman
Korstante, Marion C.
Luhr, Carroll H., Jr.
Long, Robert C.
Marshall, Thomas M.
Martin, Homer B.
Macdonald, Roderick, Jr.
Morse, Carlisle
McCarty, A. Clayton
McClure, G. David
Neustadt, David H.
Popham, Bernard I.
Radcliff, Forest F.
Reid, Ben A.
Roles, Earl
Rosenberg, Solomon J.
Rulander, John G.
Saliba, N. Alex
Scalf, Russell F.
Sehlinger, G. A.
Sonne, Louis S.
South, L. H.
Spalding, W. W.
Shrader, Edward C.
Stoutt, Glenn R.
Varga, Donald I.
Ware, Donald L.
Witten, Carroll
Wolf, Paul A.

LYNCH
Payton, Leland E.

MADISONVILLE
Arnold, Marion E.
Parsons, David W.
Trover, Faull S.

MAYFIELD
Morgan, A. Reeves

MIDDLESBORO
Wheeler, Ira F.

MILLWOOD
Embry, A. L.

MOREHEAD
Caldwell, C. Louise

MURRAY
Butterworth, A. D.

McDOWELL
McShane, I. P.

NEWPORT
Braun, Joseph G.

OWENSBORO
Yarbrough, Frank L.

PADUCAH
Pace, J. Vernon

PAINTSVILLE
Picklesimer, Frank M.
Skaggs, Ernest Gerald

PINEVILLE
Mills, Buell B.

PRESTONSBURG
Archer, George P.

RUSSELL
Johnson, Charles B.

SCOTTSVILLE
Oliver, Earl P.
Miller, Percy O.

SOMERSET
Jasper, R. B.
Long, Robert Franklin
Patterson, McLeod

TAYLORSVILLE
Skaggs, William K.

TOMPKINSVILLE
Hurt, Wendell

VALLEY STATION
Kennedy, A. C.

WHITESBURG
Adams, Lundy
Caldwell, Harry G.

WILMORE
Dunkelberger, D. E.

KSMA Members At AMA Meeting Hear Party Chairmen

KSMA members attending the AMA Annual Meeting in Miami Beach in June had an opportunity to hear the national chairman of the two major political parties.



Senator Morton

Senator Thruston B. Morton, Louisville, chairman of the Republican National Committee, and Paul M. Butler, chairman of the Democratic National Committee, addressed the 16th annual meeting of the Conference of Presidents and Other Officers of State Medical Associations on Sunday, June 12, in advance of the AMA meeting.

On the subject of health insurance for the aged, Senator Morton said that the Republican national convention would probably propose a "voluntary program to be worked out in conjunction with the states." He spoke on "Whose Nickel?"

Speaking on "Medicine and the Democratic Party," Chairman Butler predicted that his party's convention would "specifically endorse the Forand bill."

Medical Executives Meet In Florida

The Medical Society Executives Association held its annual session in Miami Beach on Saturday, June 11, preceding the AMA Annual Meeting. Entertainer Herb Shriner was the dinner speaker.

The KSMA was represented by J. P. Sanford, executive secretary, and Bobbie R. Grogan, field representative, and the Jefferson County Medical Society by Harry A. Lehman, executive secretary.

Walter Thompson, M. D., a native of Leeds, England, has started the practice of general surgery in association with **Lanier Lukins, M. D.,** and **J. B. Lukins, M. D.,** in Louisville. He graduated from the University of Leeds in 1940, interned at Norton Infirmary in Louisville in 1952 and took a residency at Norton's from 1953-7. Following his graduation from Leeds he had training at the University and Associated Hospitals in Leeds, Sheffield, and Manchester, England. He served in the Royal Army Medical Corps as a major from 1943-6, and was previously a consultant surgeon, British National Health Service.

Paul H. Wilson, M.D., has opened an office in Franklin for the general practice of medicine. A native of Waycross, Ga., Doctor Wilson was graduated from the Medical College of Georgia in 1950 and interned at Spartanburg, S. C., General Hospital. He served three years in the U.S. Army and was awarded a silver star, two bronze stars and the Purple Heart. He formerly practiced at Thomson and Eastman, Ga.; McDowell, Ky., and Williamson, W. Va.

PG Medical Opportunities Listed For Three-Month Period

Postgraduate medical opportunities in Kentucky and adjoining states for the next three-month period are announced by the KSMA Postgraduate Medical Education Office.

Special attention is called to the two-day course on chronic disease, set for October 19 and 20 at Bowling Green. This is the first of a series planned to cover various locations over the state and designed to serve the general practitioners removed from the medical centers in Louisville and Lexington.

Detailed information on the listings may be obtained from the Postgradute Medical Education Office, 104 West Chestnut Street, Louisville 2. The telephone number is JUniper 7-7135.

The complete listing follows:

August

16 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

25 Joint meeting (tentative) of the First and Third Councilor Districts, with scientific-paper presentation.

September

7-10 Postgraduate Course in "Heart Disease—With Emphasis On Newer Diagnostic Techniques—Medical and Surgical Management"; Cardiac Laboratory, Cincinnati General Hospital; limited to 75 persons; fee, $75.

20-22 KSMA Annual Meeting, Columbia Auditorium, Louisville.

20 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

26-27 Tennessee Valley Medical Assembly, Read House, Chattanooga; For information, contact Dr. Robert A. Waters, 109 Medical Arts Building, Chattanooga, Tenn.

26-30 "Anesthesia for the General Practitioner," a five-day postgraduate course offered by the University of Tennessee College of Medicine, Memphis.

October

10-14 "Postgraduate Course in Radiology," University of Tennessee College of Medicine, Memphis.

17-29 Postgraduate course, "Laryngology and Bronchoesophagology," sponsored by the University of Illinois College of Medicine, Department of Otolaryngology, under direction of Paul H. Holinger, M.D.; limited to 15 physicians. Register at the university, 1853 West Polk Street, Chicago 12, Ill.

18 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

19-20 Tentative postgraduate course, "Chronic Diseases," with lectures, panel discussion and question period; sponsored by Kentucky State Department of Health, KSMA Postgraduate Medical Fund, U. of L. School of Medicine and U. of K. Medical Center; Ole Fort Restaurant, Bowling Green, Ky.; 2 p.m. Category I credit applied for. No fees.

19-20 Louisville Society of Internists, postgraduate meeting; Louisville.

20-22 Southern Medical Association, meeting; Hilton Hotel, El Paso, Texas.

27 Fifth Annual Fall Clinical Conference of the Lexington Clinic, Lexington.

29 Kentucky Chapter of the American College of Physicians, regional meeting; Lexington, Ky.

November

3-4 "Postgraduate Course in Allergy," University of Tennessee College of Medicine, Memphis.

9-10 "Postgraduate Course in Ob-Gyn," sponsored by the KSMA Postgraduate Medical Office, Kentucky State Department of Health, University of Louisville, University of Kentucky and the Kentucky Academy of General Practice; Kentucky Hotel, Louisville, 10 a.m.; no fees; limited to 50 persons.

15 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, State Tuberculosis Hospital, District 2, Louisville.

Allergy Program Set In Pittsburgh

The Midwest Allergy Forum has scheduled its annual meeting for October 22 and 23 at the Penn Sheraton Hotel in Pittsburgh. The program will include a panel discussion on Chronic Urticaria, Drug Allergy and Repository Therapy, in addition to presentations on Bronchial Asthma, announces Philip Blank, M.D., publicity chairman of the organization.

The American Urological Association has announced its annual awards totaling $1,000 for essays on the results of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than 10 years and to hospital interns and residents doing research in urology. The first prize essay will appear on the program of the AUA meeting in Los Angeles next May 22-25. The prizes are $500, $300 and $200. Essays must be in the hands of the association's executive secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Md., before December 1, 1960.

NEWS ITEMS

Horace W. Addams, M.D., has opened an office in the Owens Medical Center, Louisville, in association with Elbert G. Christian, M.D. He specializes in medicine and neurology. A native Louisvillian, Doctor received his medical degree from the University of Louisville School of Medicine in 1949. He interned at Jackson Memorial Hospital and was a resident at Louisville's General and V.A. Hospitals from 1950-53. He served in the U.S. Army five years and 11 months, attaining the rank of first lieutenant. He practiced in Orlando, Fla., in 1956-57.

Ronald C. Almgren, M.D., has started practice in Louisville in association with Maurice Perellis, M.D., after completing two years of residency training in pediatrics at St. Joseph Infirmary, Louisville. Born in Moline, Ill., Doctor Almgren was graduated from the University of Louisville in 1955 and interned at Springfield City Hospital, Springfield, Ohio. He served as a captain in the U. S. Army from 1956-58.

Donald L. Arnett, M.D., a native of Louisville, has opened an office in Mt. Vernon for the general practice of medicine. Doctor Arnett was graduated from the University of Louisville School of Medicine in 1958 and interned at Wayne County Hospital, Eloise, Mich.

Robert E. Arnold, M.D., has discontinued the practice of medicine in Mt. Vernon. He plans to specialize in surgery at Louisville General Hospital.

Elbert G. Christian, M.D., Louisville internist, has moved his office to the Owens Medical Center, 4122 Shelbyville Road, where he is associated with Horace W. Addams, M.D. A native of Rarden, Ohio, Doctor Christian is a 1954 graduate of and former instructor in medicine at the University of Louisville School of Medicine. He started in practice in September 1958 at 321 Wallace Avenue, Louisville.

Philip S. Crossen, M.D., has entered the practice of obstetrics and gynecology in Lexington in association with James B. Stith, M.D. He has just completed specialty training at St. Louis Maternity Hospital, where he was chief resident the past two years. Also, as a recipient of an American Cancer Society clinical fellowship, he did research in the field of gynecologic cancer. A native of St. Louis, Doctor Crossen received his M. D. degree from Washington University there in 1954.

C. Charles Hugan, Jr., M.D., a native of Detroit, has opened an office in Covington for the practice of internal medicine. Doctor Hugan was graduated from Emory University in 1953, interned at Western Reserve University, Cleveland, and took his residency training at Western Reserve and Henry Ford Hospital, Detroit. He was in the U.S. Navy from 1955-57, attaining the rank of lieutenant.

Harry Denham, M.D., Maysville, was a delegate from the Fifth District to the Democratic National Convention in Los Angeles in July. He was elected at the state convention held in Louisville.

Louis M. Foltz, M.D., Louisville, chairman of the Kentucky Commission on Alcoholism, represented the commission at the 26th International Congress on Alcohol and Alcoholism in Stockholm, July 30-August 5. Doctor Foltz has been spending seven weeks in Europe visiting psychiatric hospitals and clinics in England, France, Switzerland, Italy, West Germany, Holland, Denmark and Sweden. He is accompanied on the trip by his wife and two daughters.

Austin F. Finley, M.D., Madisonville, a practicing physician in Hopkins county for 56 years, has been appointed medical director of the Hopkins County Health Department. He succeeds Layman B. Swann, M. D., Robards, who resigned after serving three years as head of the health unit. Doctor Finley began the practice of medicine in St. Charles in 1904 and has been in Madisonville since 1920.

For **Clyde L. Garr, M.D.,** 1960 marks the 50th anniversary of his graduation from the University of Louisville College of Medicine and his 47th year as a physician in Flemingsburg. During his long practice he has delivered approximately 2,800 babies and worn out about 35 automobiles. Doctor Garr has remained at the same location where he joined his father, the late Dr. C. R. Garr, in 1913.

Martyn A. Goldman, M.D., is completing his last year of residency at Kosair Crippled Children Hospital, Louisville, after three years of training at Chicago Wesley Memorial Hospital and Veteran Administration Research Hospital. His specialty is orthopedics. Born in Chicago, Doctor Goldman received his M.D. degree from Northwestern University and interned at Chicago Wesley Memorial Hospital. He served in the U. S. Army from 1955-57 with the rank of captain.

A. Myron Johnson, M.D., Wilmore, has been awarded a $4,800 grant by the Wyeth Fund for Postgraduate Medical Education, Philadelphia, for advanced study in the care and treatment of children.

Rex O. McMorris, M.D., medical director of Louisville's Rehabilitation Center since it was opened in 1954, has accepted the post of medical director of the Institute of Physical Medicine and Rehabilitation, Peoria, Ill. He will leave Sept. 1 to begin his new work. Doctor McMorris has been associate professor and chairman of the Department of Physical Medicine and Rehabilitation at the University of Louisville School of Medicine since 1954 and associate in occupational health since 1955. He has also been medical director of the Rehabilitation Center, Evansville, Ind., and of the United Cerebral Palsy Clinic, Louisville.

NEWS ITEMS

John R. Gleason, M.D., has started the practice of medicine in Shepherdsville in association with W. B. Hamilton, M. D. A native of Louisville, Doctor Gleason was graduated from the University of Louisville School of Medicine in 1957 and interned at the U. S. Naval Hospital, Portsmouth, Va. He served three years in the U. S. Navy with the rank of lieutenant.

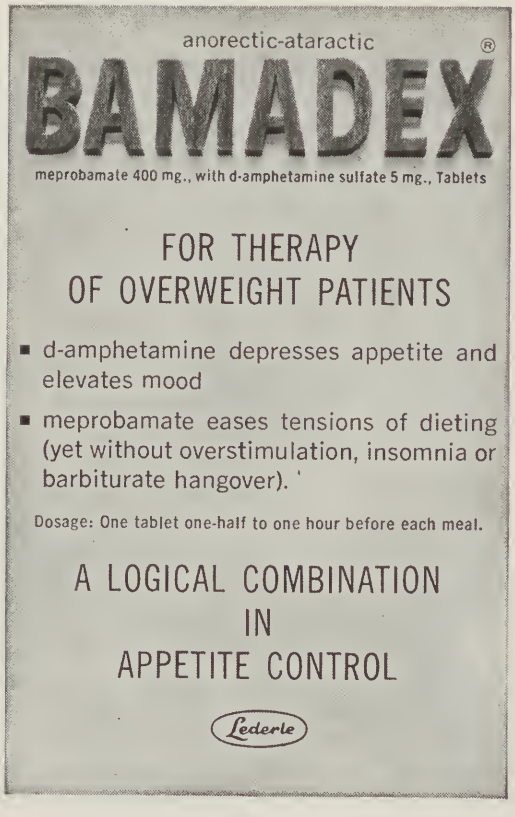
Emil Kotcher, Sc.D., associate professor of microbiology at the University of Louisville School of Medicine, has resigned as director of the Division of Public Health Laboratories, State Department of Health, to return to the school full time to teach and to carry out research. The imminent move of the division to Frankfort caused Doctor Kotcher to give up the Health Department post, which he had held two years.

Robert A. Stansbury, M.D., has started in practice in Louisville in association with Alfred O. Miller, M.D., with offices in the Francis Building and Owens Medical Center. His specialty is radiology. A native of Louisville, Doctor Stansbury was graduated from the University of Louisville School of Medicine in 1954. He interned and took three years of residency training at St. Joseph Infirmary, Louisville. He served in the U. S. Army from 1958-60 with the rank of captain.

Richard J. Menke, M.D., has opened an office in his native Covington, specializing in orthopedic surgery. A 1953 graduate of St. Louis University, Doctor Menke interned at St. Elizabeth Hospital, Covington. He received his residency training in general and orthopedic surgery at Henry Ford Hospital. He was a captain in the U. S. Army Medical Corps from 1955-57.

Wellington B. Stewart, M.D., has joined the Department of Pathology at the University of Kentucky Medical Center, Lexington. He formerly was associate professor of pathology at the College of Physicians and Surgeons, Columbia University, and associate attending pathologist at Presbyterian Hospital, New York City. A native of Chicago, Doctor Stewart received his medical degree from the University of Rochester in 1945. He interned and took his residency training at Strong Memorial Hospital, Rochester, N. Y. He served as a captain in the U. S. Army Medical Corps from 1946-48.

Fred R. Scroggin, M.D., Williamstown, is one of five northern Kentucky sportsmen nominated from the Fifth Wildlife Region for membership on the Kentucky Department of Fish & Wildlife Resources Commission. Doctor Scroggin, a past president of the League of Kentucky Sportsmen, was recently named "Kentucky Sportsman of the Year."



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In Memoriam

G. C. LEACHMAN, M.D.
Louisville
1877 - 1960

George C. Leachman, M.D., Louisville surgeon who retired in 1956 after a 60-year practice, died June 26 in Louisville at the age of 83. He served 55 years as physician of the Louisville Colonels Baseball Club and believed himself to be the dean of baseball-team physicians.

The son of a Louisville physician, Doctor Leachman became the team physician in 1901. He began practicing surgery in 1910 after studying at various clinics throughout the country. During World War I he served as an Army Medical Corps major.

J. HAROLD MEYER, M.D.
Louisville
1898-1960

J. Harold Meyer, M.D., Louisville obstetrician, died of a heart attack at his home on July 18. He was 62.

Born in Louisville, Doctor Meyer had practiced in his native city for 30 years. He was a graduate of the University of Louisville School of Medicine.

W. H. RICE, M.D.
Ashland
1896-1960

William H. Rice, M.D., chief surgeon for the Ashland Works, Armco Steel Corporation, died June 25 in a New York hospital. He became ill while attending a medical meeting in that city.

A graduate of the University of Vermont Medical College, Doctor Rice was a former medical missionary in India. He went to Ashland from Osborne, Ohio, in 1924.

U of L Receives $3,500 Grant

The Commonwealth Life Insurance Company recently made another $3,500 grant to the University of Louisville Medical School—bringing its total in 11 years to $32,500 according to J. Murray Kinsman, M.D., dean of the school, who said the gift can be applied to any research purpose the school chooses.

Schools of professional and practical nursing enrolled an estimated 71,297 new students in 1959, compared with 68,851 in 1958, it has been announced by Fred C. Foy, chairman of the Committee on Careers, National League for Nursing, New York. New admissions to professional nursing programs reached 47,797, a slight increase over the 47,351 total of the preceding year. Practical nursing schools admitted an estimated 23,500 students in 1959, compared with 21,500 in 1958.

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PERTINENT PARAGRAPHS

The Southern Surgical Congress announces the Prize Scientific Paper Award Contest eligible to residents of approved hospitals in the Southeastern states for the best scientific papers. Entries are due at the Congress office, 340 Boulevard, N. E., Atlanta 12, Ga., before December 1, according to J. D. Martin, Jr., M.D., chairman of the committee in charge. First prize is an all-expense-paid trip to the meeting at Miami Beach, March 6-9, 1961, plus a cash award.

Physicians now head the health departments of 96 Kentucky counties—as compared to 62 in 1958—reports Edwin H. West, M.D., director of the State Health Department's Bureau of Local Health. The number of health officers is 36—each in charge of one to five counties. Doctor West pointed out that the State's new indigent-medical-care program, scheduled to start the first of next year, makes it important that as many counties as possible have medical officers.

The Association of Military Surgeons of the U. S. has set October 31-November 2 for its 67th annual convention to be held at the Mayflower Hotel in Washington, D.C. "The Military Role In Medical Progress" is announced as the theme. The association has its headquarters at 1726 Eye Street, N. W., Washington 6, D.C.

Ephebiatrics, on adolescent medicine, will soon take its rightful place in the practice of medicine, says an article in a recent issue of the New Physician, official journal of the Student American Medical Association. With the advent of antibiotics and modern therapeutic techniques, the practice of acute pediatrics as the main mission of the pediatrician is giving way to more of a preventive practice . . . and the adolescent is an example of the changing scene, write Frederick C. Biehusen, M.D., and Leonard M. Hebertson, M.D., of the postgraduate ephebiatric clinic at Letterman Army Hospital, San Francisco. The clinic derived its name from the Greek word meaning approaching manhood.

Dr. Wicker Honored on Birthday

Melvin V. Wicker, M. D., who has practiced in Wayland and vicinity for 49 years, was honored by his family with a dinner recently marking his 75th birthday. Mrs. Wicker and his four daughters were hostesses at the birthday dinner given in his honor.

A graduate of the University of Louisville Medical School in 1910, Doctor Wicker is a past president of the Floyd County Medical Society, a former member of the Floyd County Board of Education, and ex-mayor of Wayland. A few years ago he was named Floyd County's Grandfather of the Year (he has 16 grandchildren and 7 great-grandchildren) and later was made a member of Floyd County Hall of Fame.

AMA Clinical Meet Nov. 28-Dec. 1

The American Medical Association has announced that application forms are now available for space in the Scientific Exhibit at its next Clinical Meeting in Washington, D.C., November 28-December 1. Requests should be addressed to Charles H. Bramlitt, M.D., Director, Department of Scientific Assembly, American Medical Association, Chicago 10. Applications close August 1.

The "Hull" award will be presented for the first time at this meeting to the best exhibit on a scientific subject which has not been shown previously at a medical meeting.

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Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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IN THE BOOKS



PRIMARY TUMORS OF THE CALVARIA: by Franklin Jelsma, M.D.; published by Charles C. Thomas, Publisher, Springfield, Ill.; 1960; 116 pages; price, $7.

This compact, easily readable presentation is highly recommended as a companion to those facing the problem of deciding the proper approach to diagnosis and management of tumors of the calvaria.

This monograph includes a brief discussion with representative cases of each type of tumor encountered. In many incidences a brief differential diagnosis is presented. Suggested management is outlined and many of the cases have long follow-up reports adding to the general interest.

Excellent X-ray plates are presented, having typical appearance of most of the lesions.

A very adequate bibliography accompanies the monograph.

I think this monograph fills a very necessary place since, as far as I know, there is no other source readily available to aid one in the management of this problem.

Richard L. Roth, M.D.

A TEXTBOOK OF GYNECOLOGY: by Laman A. Gray, M.D. Louisville; published by Charles C. Thomas, Publisher, Springfield, Ill.; 470 pages; price $15.50

In "A Textbook of Gynecology," Dr. Laman Gray has provided a much-needed new and up-to-date treatise suitable for use as a text in undergraduate courses in Gynecology. The book covers the essential material thoroughly and with exemplary lucidity of expression and clarity of style. Especially noteworthy is the clear exposition of the more complex concepts of the subject, notably the chapters on hormones in gynecology, on hermaphroditism and congenital anomalies, and on endometriosis.

Worthy of special mention is the short and sympathetically written final chapter on "Gynechiatry," the contribution of Dr. William Keller, who has provided both an ingenious verbal coinage and a well-balanced discussion of a delicate and important aspect of gynecologic practice.

The book is copiously illustrated by tone drawings, photomicrographs and color plates. These are uniformly beautifully reproduced. The author has included illustrations of surgical techniques which may appear to some teachers inappropriate in a student text, even though in his preface Dr. Gray defends their inclusion on the basis that, "Gynecology has a strong Kellyian (*sic*) background." This possible defect is offset, however, by the commendable emphasis throughout the work on pathologic anatomy, a subject of which the author is an able and experienced teacher, and which he rightly considers to be the essential basis for an understanding of gynecology.

The sturdy binding and large, readable type of the volume will add to its usefulness as a student text. This excellent contribution to gynecological literature deserves long life and wide use.

Douglas M. Haynes, M.D.

THE 1959 INSTRUCTIONAL COURSES OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS: by 29 authors.

This volume is the first issue of "Instruction Courses of the American Academy of Orthopaedic Surgeons" to be distributed to the medical profession at large. It is a yearly volume and has been issued since 1943, this being Volume XVI.

There are 29 authors, each an expert on the subject presented. Several of the subjects have been arranged in symposia.

Part one, a "Symposium on Injuries to Athletes" is well written and timely with advice as to cause, prevention and treatment of the injuries.

Part two consists of lectures on the hand in which Dr. Luck presents a new concept of Dupuytren's Contracture.

Part three considers the therapy of congenital club foot, metatarsus varus, pes valgus or vertical talus. Each writer has described the latest and best tested procedures.

Part four describes Injuries and Afflictions of the Menisci and treatment. This chapter is well illustrated with photographs and line drawings so that any resident or orthopaedist can understand the text.

In part five, Dr. Chester C. Schneider deals with the Industrial Low Back Cripple and the Mayo Group give their results from operative procedures on the protruded disc. Scoliosis with treatment is ably described by Dr. Albert Schmidt.

Part six deals with miscellaneous orthopaedic subjects. One paper especially is notable. "The Surgical Care of Unequal Extremities" and "Measurement and Prediction of Growth" which is essentially the experience of the Newington Hospital in Hartford, Conn.

Part seven considers the use of Hip Prostheses in fresh fractures by men who have designed the different types of metal implants. Their wise observations are recorded.

As a whole the volume should be read by all orthopaedic residents, traumatic surgeons and orthopaedists because the articles were composed by the experts on each subject.

K. Armand Fischer, M.D.



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Dosage

ADULTS: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

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Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica.* In 15 of these subjects, nine stool specimens were required to establish the diagnosis.[2]

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.[3]

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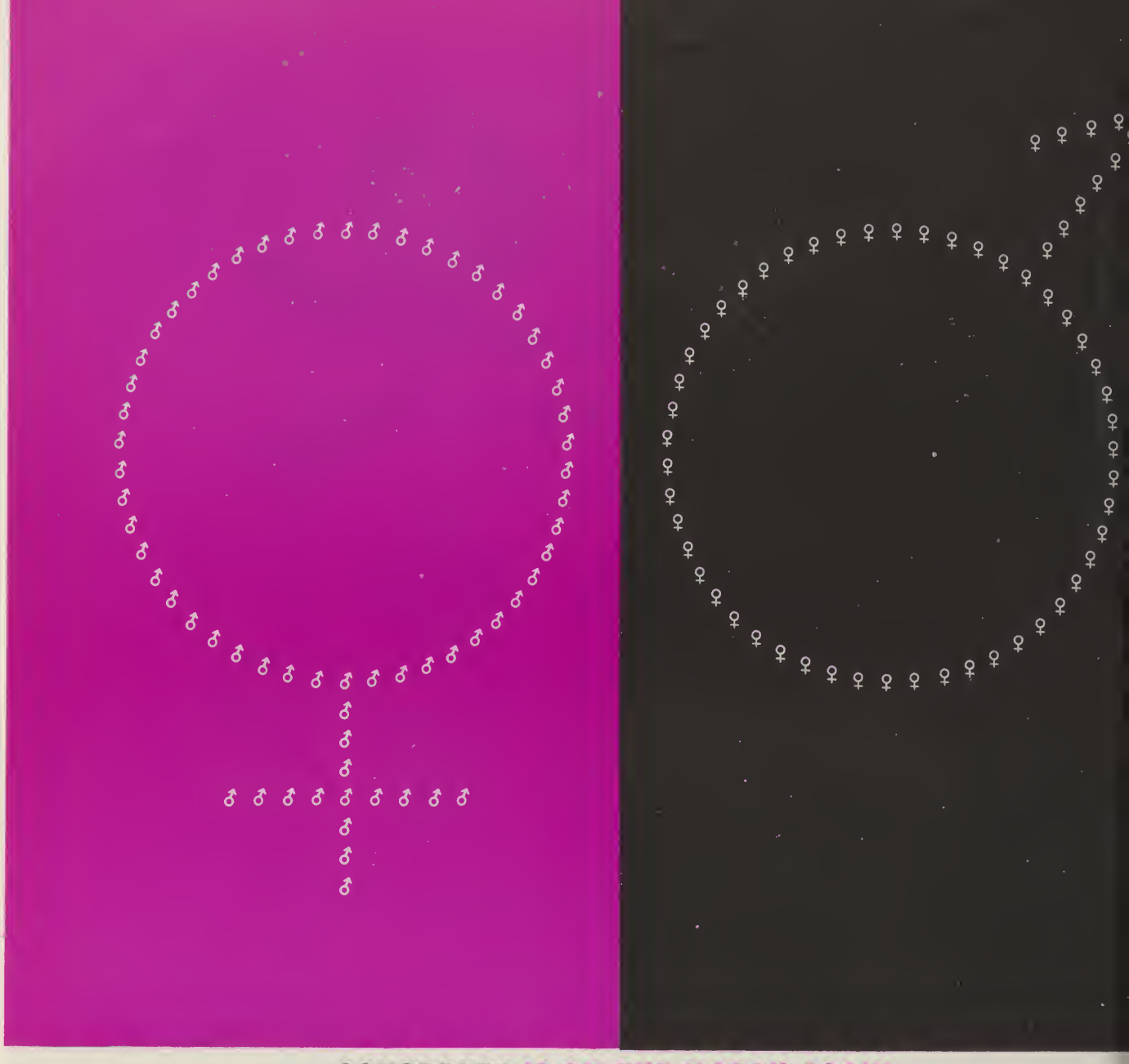
1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. *6*:1821 (Dec., 1955).

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. *9*:897 (June, 1958).

*U.S. Pat. No. 2,864,745

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* Marmell, M., and Prigot, A.: Tetracycline phosphate complex in the treatment of acute gonococcal urethritis in men. Antibiotic Med. & Clin. Ther. 6:108 (Feb.) 1959.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



THE patient was a 22 year old married, white primigravida who consulted her physician in the third month of her pregnancy. Her past history was negative; she had had the usual childhood diseases with no previous surgery. Her physical examination was normal. By menstrual history she was due July 25, 1958, her last period having begun on October 18, 1957.

The patient's prenatal course was essentially normal. On the 26th of July she had some ankle edema and a trace of albumin in the urine. Her blood pressure was within the normal limits although there was a 10-point increase in the diastolic reading over the previous visit. Her weight gain during the interval was only one pound. She was treated with Diuril, 250 mg. every other day plus a salt free diet. She had a spontaneous onset of labor and entered the hospital at 4:30 p.m., 7/29/58. No mention was made of any abnormalities present at this time. The first stage of labor lasted twelve hours. She received sedation at 6:20 p.m., 50 mg. Leritine plus 1/150 gr. Scopolamine i.m. and the Leritine 50 mg. was repeated i.m. at 11:16 p.m.

The cervix was completely dilated at 4:00 a.m., 7/30/58, and the patient was taken to the delivery room at 4:20 a.m. The membranes ruptured at 4:24 a.m. The blood pressure was 116/68. pulse 120. The patient was described as in good condition though respiration ceased temporarily just previous to the time of the episiotomy, at 4:31 a.m., but the patient began breathing again without assistance. Just after the episiotomy, however, she required artificial respiration for a short time. Low forceps were applied at 4:32 a.m. with delivery of an 8 lb. 12 oz. girl in good condition. The placenta followed immediately, together with approximately 300 cc. of dark blood. Pitocin ½ cc. i.m. was given at 4:38 a.m. and Methergine 1/320 gr. i.m. at 4:39 a.m. Suddenly no pulse or blood pressure was obtainable. At 4:43 a.m. adrenalin 8 minims was given i.v. followed with 8 minims administered directly into the cardiac muscle, but this failed to stimulate any cardiac contractions. A surgeon was called and arrived in four minutes but it was felt it was too late to attempt open cardiac massage.

The patient was pronounced dead at 4:43 a.m.

An autopsy was requested but the relatives refused. The clinical impression was intrapartum death due to coronary embolism with coronary occlusion, possible source amniotic fluid.

Comment

The Committe felt this was a direct obstetrical death that could well have been from amniotic fluid embolism plus possible hypofibrinogenemia; however, without an autopsy this could not be proved. This case abstract contained more precise information than is often supplied. The time interval between spontaneous rupture of the membranes and temporary cessation of respiration was quite helpful. Often in such an emergency there is insufficient personnel to record the sequence of events in addition to treatment.

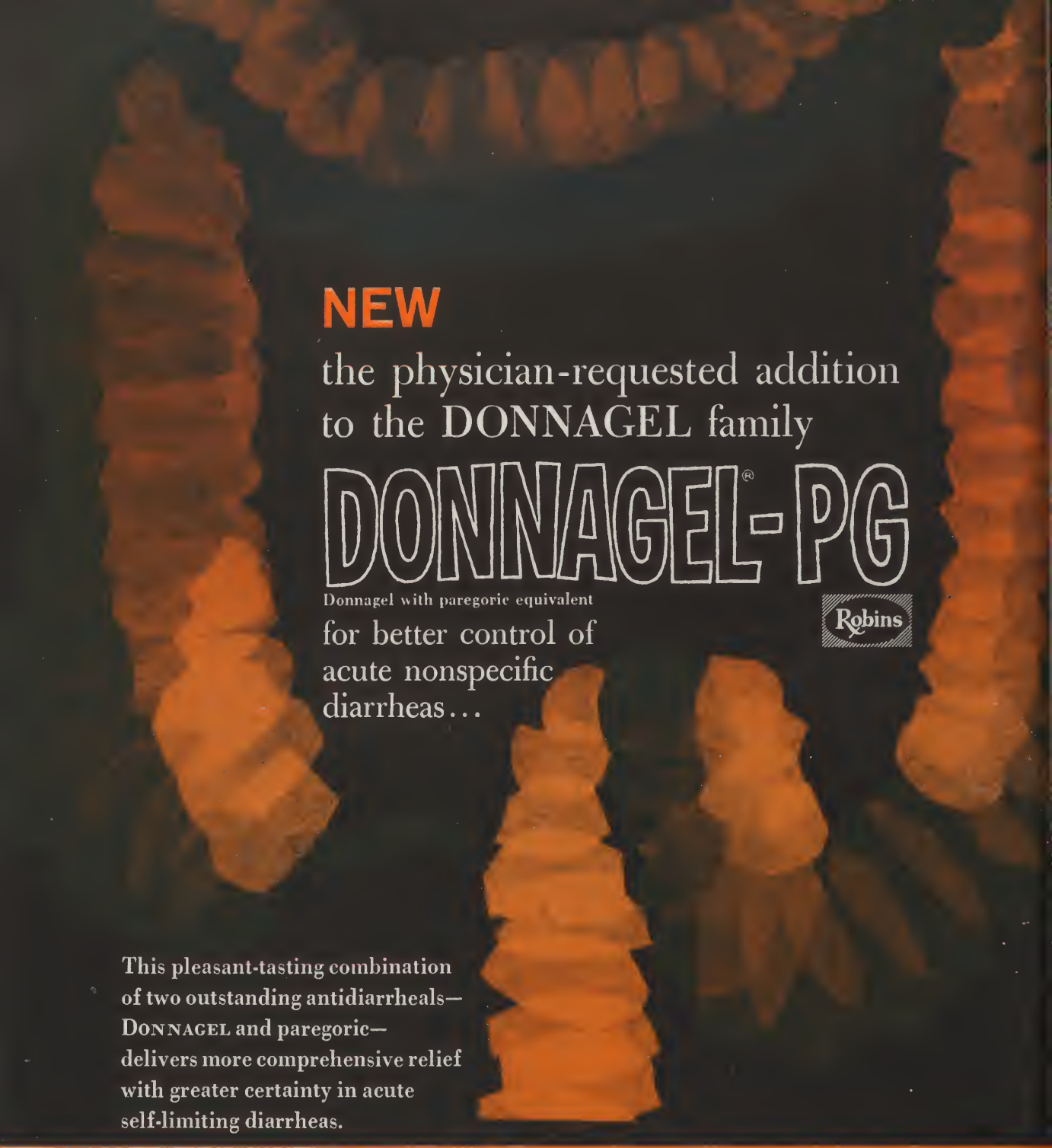
It is well known that sudden release of a large quantity of amniotic fluid can cause an abruptio placentae, which was true in this case. How often is abruptio placentae associated with hypofibrinogenemia? Beischer, from the Royal Women's Hospital in Melbourne, Australia, reviewed 20 patients with hypofibrinogenemia in M.J., Australia, 2:180, 1959. The Australian incidence was 3.5%. Kimbrough, in the American Journal of Obstetrics & Gynecology, 78:1161, 1959, reviewed 383 cases of abruptio and 169 cases of placenta previa during the years 1944 to 1957. In his series there were four patients with clinically significant hypofibrinogenemia. If his cases were evenly divided over the 14 years, their incidence would be close to the Australian incidence of around 3.3%. The above is mentioned so we won't be too quick to administer fibrinogen unless there is good evidence to justify not only the costly administration, but the possibility of subsequent hepatitis. This is stated by some authorities to run as high as 20%.

In this case, if the patient did die from an amniotic fluid embolism there was no other therapy that could have altered the outcome.

Month of Pregnancy

	1	2	3	4	5	6	7	8	9			
									1	2	3	4
Blood Pressure			138/80	138/78	128/72	120/80	134/84	120/70	138/88	120/70	128/80	120/70
Weight			110½	117½	127½	128½	129	130	130¼	133	134	133½
Urine			neg	neg	neg	neg	neg	neg	neg	neg	tr alb	tr alb

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Pectin .....142.8 mg.
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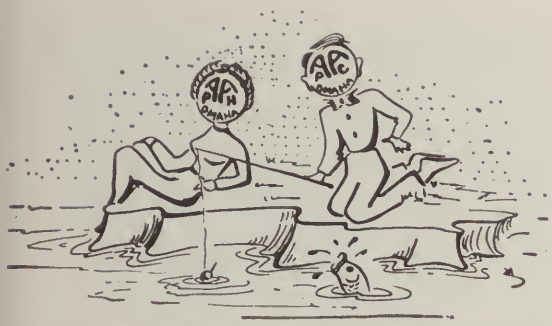
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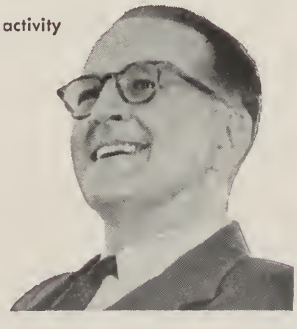
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PUBLIC HEALTH PAGE

National Syphilis Serology Evaluation*

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health, Commonwealth of Kentucky*

OCCASIONALLY the question is raised, "How accurate is the syphilis serology laboratory of the State Department of Health?" In order to answer this question and to evaluate the performance of this laboratory with other state and national laboratories, the Division of Public Health Laboratories participates in the Public Health Service serologic evaluation study.

This study is carried out by sending 20 prepared serum specimens each month for ten months to all participating laboratories. The 200 serums, distributed under code numbers, include duplicates of 100 prepared serums. The 64 participating laboratories include the central laboratories of the 50 states, the District of Columbia, New York City, British Guiana, Denmark, El Salvador, Mexico, Peru, Puerto Rico, the Virgin Islands, Venereal Disease Research Laboratory, and the test-author laboratories of Drs. Kahn, Kline, Kolmer, and Mr. Mazzini.

In accordance with the recommendations of the National Advisory Serology Council, tests performed at the Venereal Disease Research Laboratory serve as controls for this study. Tests performed at this Laboratory were restricted to those listed in the 1959 Manual of Serologic Tests for Syphilis (PHS Pub. No. 411, revised).

The following results were obtained by the Syphilis Serology Section during the past year (Fiscal Year 1960), the results being based on 200 serum samples:

A. Reproducibility (Qualitative Tests)

1. Kahn Standard (Lipoidal Antigen)	
Kentucky—Match—200	100 %
National Average	99.84%
2. Kolmer Qualitative (Cardiolipin Lechithin Antigen)	
Kentucky—Match—200	200 %
National Average	99.40%
3. VDRL Slide (Cardiolipin Lechithin Antigen)	
Kentucky—Match—200	100 %
National Average	99.42%

B. Disagreement with Control Performance in Individual Serums (Quantitative Tests)—within 10%

1. Kahn Standard			
Dr. Kahn's Laboratory	—More sensitive	—5%	Total 5%
Kentucky	—More sensitive	—5%	Total 5%
National Average	—More sensitive	—4.49%	
	—Less sensitive	—0.60%	Total 5.09%
2. Kolmer Qualitative			
Dr. Kolmer's Laboratory	—More sensitive	—7.14%	
	—Less sensitive	—0 %	Total 7.14%
Kentucky	—More sensitive	—2.55%	
	—Less sensitive	—2.55%	Total 5.10%
National Average	—More sensitive	—3.86%	
	—Less sensitive	—1.20%	Total 5.07%
3. VDRL Slide			
Kentucky	—More sensitive	—2.00%	
	—Less sensitive	—2.00%	Total 4.00%
National Average	—More sensitive	—1.36%	
	—Less sensitive	—2.60%	Total 4.02%

On the basis of this report, the Syphilis Serology Section continues to distinguish itself for its high level of accuracy and performance.

Another factor about the Syphilis Serology Section that is sometimes not appreciated by physicians and laymen is the volume of specimens tested. During the past two years, this section has tested about 12,000 serum samples per month. As high as 17,000 serums have been received some months. The average daily load of serum specimens is 600, but some days may go as high as 1,000 specimens. Practically all specimens are tested the day they are received and reports are mailed out in a day or so. Anyone familiar with this type of work can appreciate the tremendous service the personnel of this section are giving to the people of Kentucky.

Prepared by Emil Kotcher, Sc.D., Director, Division of Public Health Laboratories, Kentucky State Department of Health.

State's Income From Insurance Totals $6 Million a Year

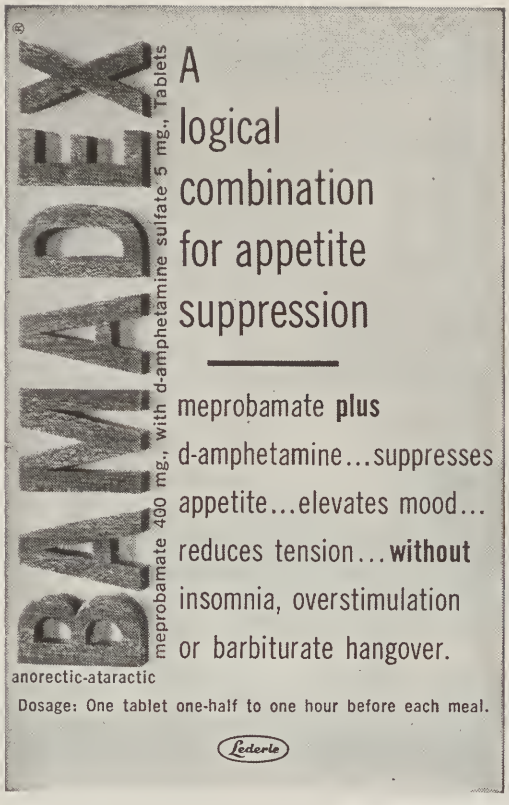
Kentucky has a multi-million revenue from taxes on insurance companies each year, a report published in a recent issue of the Journal of American Insurance reveals. The yearly total in state taxes and fees paid to the Commonwealth by its 700 licensed insurance companies is listed at $6,214,095.55.

Annual expenditures for state insurance-department operations amount to $289,595.72 or 4.66 per cent of insurance funds.

According to the report, total state premium volume of all companies in Kentucky is $327,790,531; premium and franchise taxes amount to $5,890,099.77; and fees collected total $323,995.78.

The figures are based on 1958 nationwide data of the Insurance Industry Committee of Ohio.

The Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va., reports the largest attendance in its history at the 33rd Annual Spring Congress in Opthalmology and Otolaryngology and allied specialties. Some 300 physicians and their wives from 40 states were present. The 34th Spring Congress is set for April 9-14, 1961.



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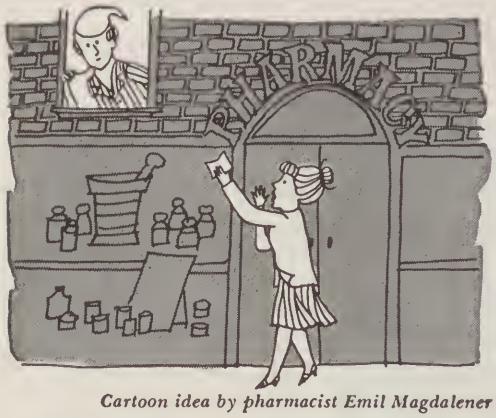
DOSAGE:

Lupus. Average initial adult dose, 1 or 2 tablets after meals and at bedtime. Dosage should be reduced gradually at two week intervals to 1 or 2 daily.

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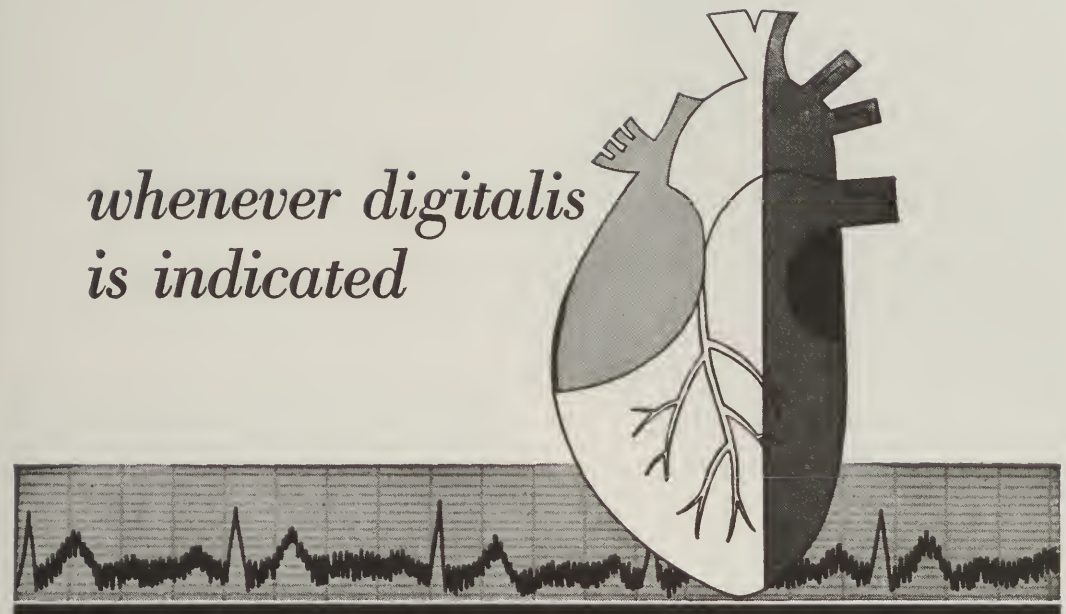
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Lown, B., and Levine, S. A.: Current Concepts in Digitalis Therapy, Boston, Little, Brown & Company, 1954, p. 23, par. 2.

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1. A. M. A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

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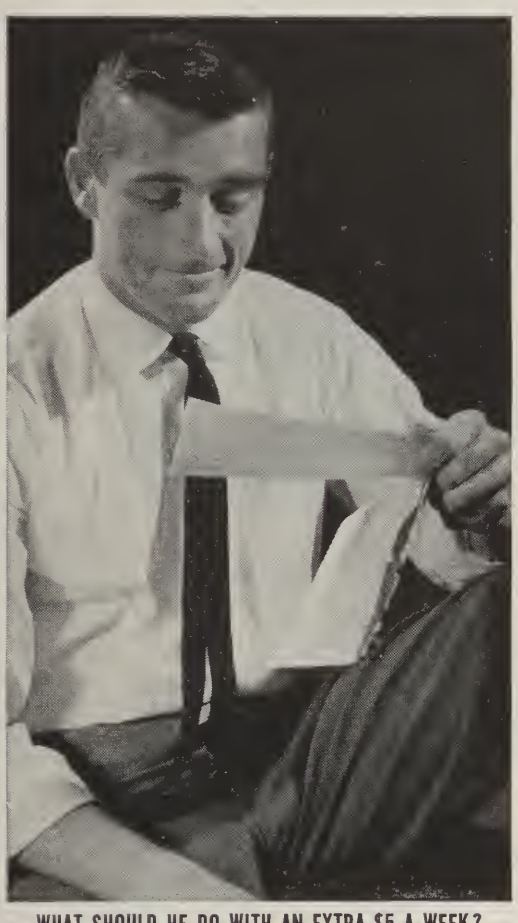
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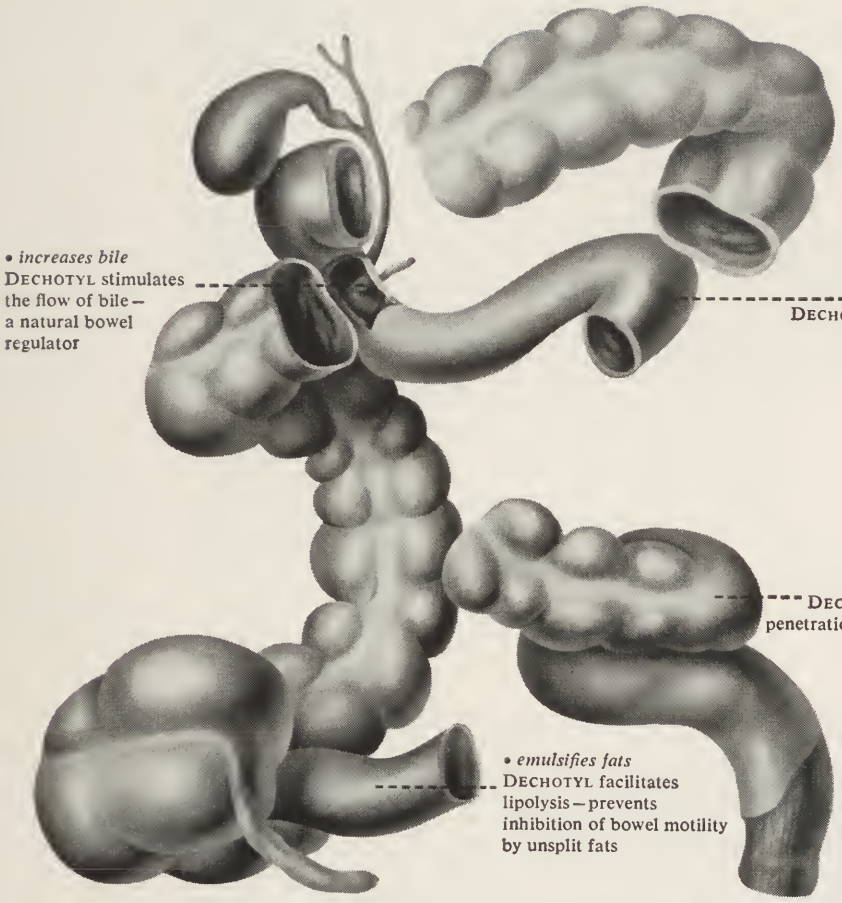
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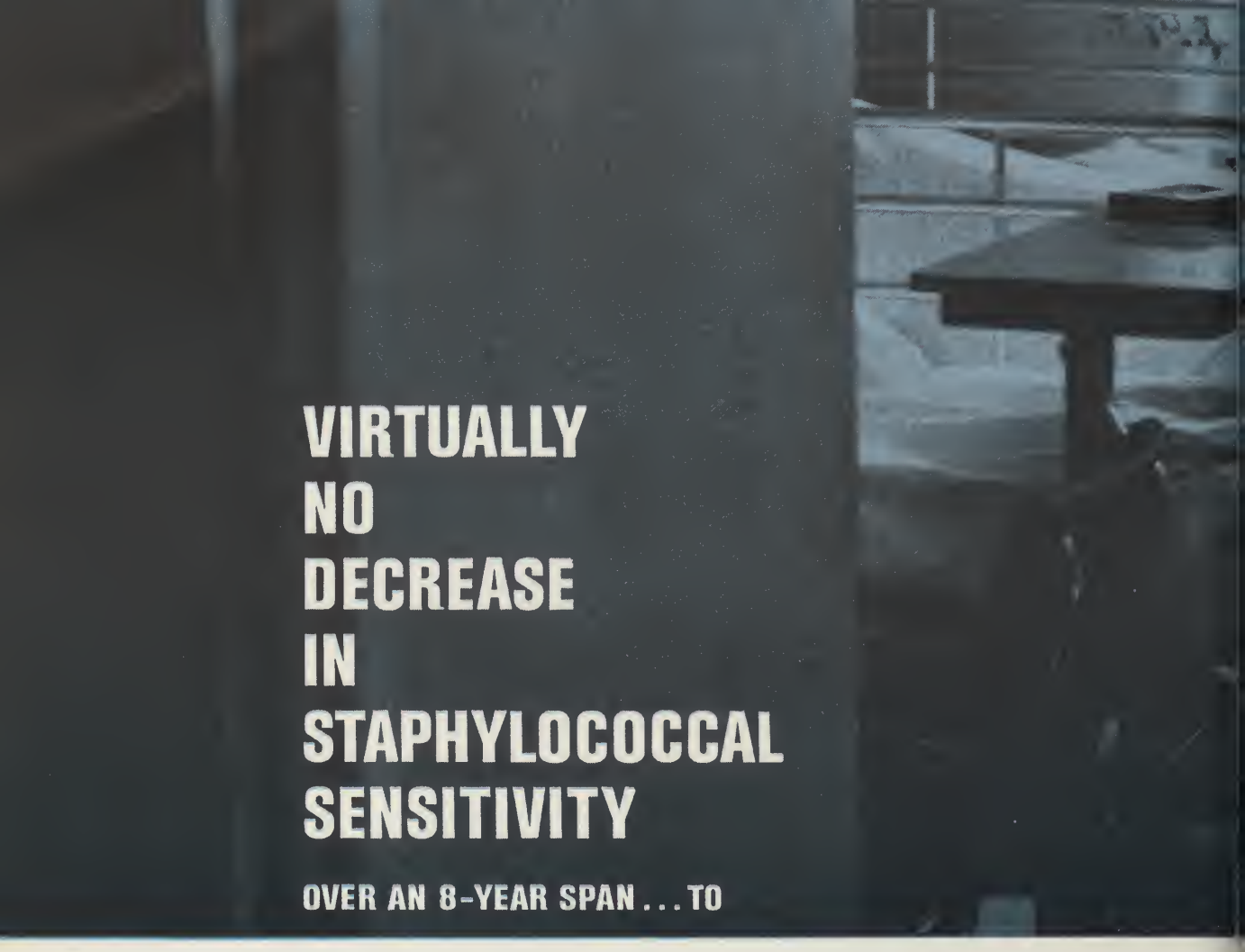
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KENTUCKY STATE MEDICAL ASSOCIATION
ORGANIZED 1851

SEPTEMBER 1960 · VOLUME 58 · NUMBER 9



VIRTUALLY NO DECREASE IN STAPHYLOCOCCAL SENSITIVITY

OVER AN 8-YEAR SPAN . . . TO

CHLOROMYCETIN

(chloramphenicol, Parke-Davis)

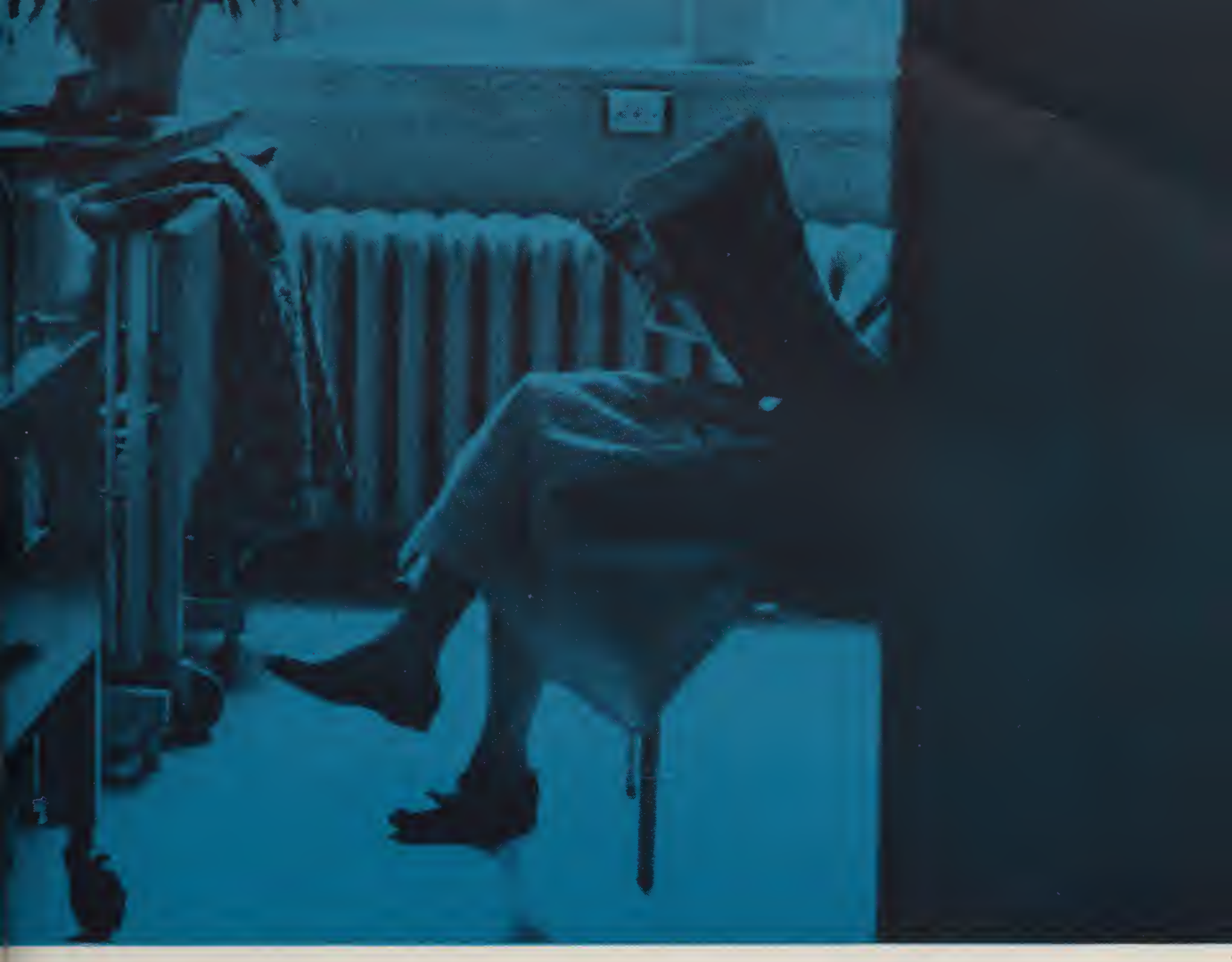
An outstanding and frequently reported characteristic of CHLOROMYCETIN[1-8] "...is the fact that the very great majority of the so-called resistant staphylococci are susceptible to its action."[1] In describing their study, Rebhan and Edwards[2] state that "...only a small percentage of strains have shown resistance..." to CHLOROMYCETIN, despite steadily increasing use of the drug over the years.

Fisher[3] observes: "The over-all average incidence of resistance, for the 31,779 strains [of staphylococci] through nine years was about 9%." Finland[4] reports that, while the proportion of strains resistant to several newer antibiotics has risen to between 10 and 30 per cent, such resistance to CHLOROMYCETIN "...has been rare even where this agent has been used extensively." Numerous other investigators concur in these findings.[5-8]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

References: (1) Welch, H., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 1. (2) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* 82:513, 1960. (3) Fisher, M. W.: *Arch. Int. Med.* 105:413, 1960. (4) Finland, M., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 187. (5) Bercovitz, Z. T.: *Geriatrics* 15:164, 1960. (6) Glas, W. W., & Britt, E. M.: Management of Hospital Injections, in Symposium on Antibacterial Therapy, Michigan & Wayne County Acad. Gen. Pract., Detroit, September 12, 1959, p. 7. (7) Staphylococcal Infections in Pediatrics, Scientific Exhibit, Commission on Professional and Hospital Activities, 108th Ann. Meet., A. M. A., Atlantic City, June 8-12, 1959. (8) Robinson, H. M., Jr.; Robinson, R. C. V., & Raskin, J.: *Postgrad. Med.* 27:522, 1960.



V LO SENSITIVITY OF PYOGENIC STRAINS OF STAPHYLOCOCCI TO CHLOROMYCETIN OVER A PERIOD OF EIGHT YEARS*



is; were gathered over almost a decade on 329 children with staphylococcal pneumonia; 1,663 sensitivity tests were performed.

rom Rebhan & Edwards.[3]

10060

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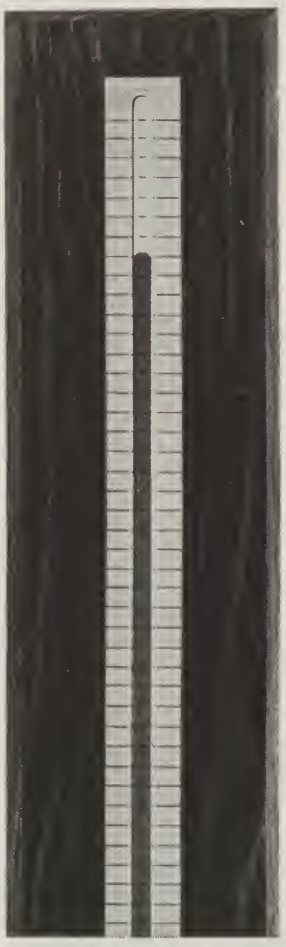
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References: 1. Reports to the Squibb Institute, 1960. 2. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 3. Stenberg, E. S., Jr.; Benedetti, A., and Forsham, P. H.: Op. cit. 5:46 (Feb.) 1960. 4. Fuchs, M.; Moyer, J. H., and Newman, B. E.: Op. cit. 5:55 (Feb.) 1960. 5. Marriott, H. J. L., and Schamroth, L.: Op. cit. 5:14 (Feb.) 1960. 6. Ira, G. H., Jr.; Shaw, D. M., and Bogdonoff, M. D.: North Carolina M. J. 21:19 (Jan.) 1960. 7. Cohen, B. M.: M. Times, to be published. 8. Breneman, G. M. and Keyes, J. W.: Henry Ford Hosp. M. Bull. 7:281 (Dec.) 1959. 9. Forsham, P. H.: Squibb Clin. Res. Notes 2:5 (Dec.) 1959. 10. Larson, E.: Op. cit. 2:10 (Dec.) 1959. 11. Kirkendall, W. M.: Op. cit. 2:11 (Dec.) 1959. 12. Yu, P. N.: Op. cit. 2:12 (Dec.) 1959. 13. Weiss, S.; Weiss, J., and Weiss, B.: Op. cit. 2:13 (Dec.) 1959. 14. Moser, M.: Op. cit. 2:13 (Dec.) 1959. 15. Kahn, A., and Grenblatt, I. J.: Op. cit. 2:15 (Dec.) 1959. 16. Grollman, A.: Monographs on Therapy 5:1 (Feb.) 1960.

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And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

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Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

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MESSAGE FROM THE PRESIDENT

A Good Citizen

WHEN an intelligent individual is considering a community in which to live, he carefully surveys certain factors: the potential market for his services, the residential district both in terms of the present and the future, the quality of the public utility services, the transportation facilities, the school system, the hospitals, the recreational outlets, and such cultural benefits as may be present. Should the completed study indicate that each one of the cardinal factors is being evenly developed, this individual has found a growing city.

In addition to natural endowments contingent on geographical location, a growing city is dependent on three essential elements: an aggresive and progressive municipal government, a corps of individual agencies to assist in the community's social planning and development, and an army of volunteer workers to raise the funds and to assume managerial responsibility for the agencies.

Municipal government is in relation to the size of its community always big business. The control and management of this business is intrusted into the hands of individuals elected by the community. While no one person can hope to influence greatly the choice of candidates for a public office, any one individual can in a number of ways definitely indicate his choice of the candidate best suited to a particular office. Such men must plan for the future. The schools, traffic control, annexation, sewage disposal, and property zoning are vital problems of local current interest. Either the wisdom or the lack of it in their decisions becomes apparent only during the next decade.

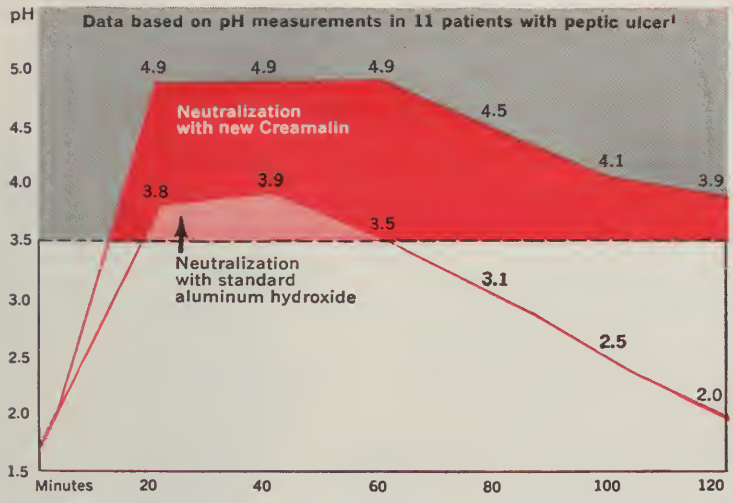
Webster defines a parasite as "a person who lives at the expense of another or others without making any useful contribution or return." The person who takes a reasonable, active interest in politics, who contributes to local charities in accordance with his means, and who offers a fair share of his time for volunteer work not only has civic pride but that person is a good citizen.

Louis Ahlf Jr.

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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

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1. Rein, C. R., and Fleischmajer, R.: The efficacy of tetracycline phosphate complex (TETREX) in dermatological therapy. Antibiotic Med. & Clin. Ther. 4:422 (July) 1957.

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THE INSURANCE PAGE



Blue Shield And Our National Leadership

THE American Medical Association's recent declaration of renewed support for Blue Shield demonstrates that the national leadership of our profession recognizes the importance most of us in the state and county medical societies long ago attached to our support of our local Plans. In its essence, the action of the A.M.A. House of Delegates comprises an acknowledgment that medicine's own sponsored Blue Shield prepayment plans need all the support, understanding and guidance we can give them—at every level of our professional activity.

Although each of the nation's 68 Blue Shield Plans was created by local county or state societies to meet the particular needs of their own communities, the emergence of medical care as a national issue has compelled our profession to forge Blue Shield into an instrument capable of meeting and solving prepayment problems on a national scale.

In the past two decades, both management and labor have firmly embraced the principle of industry-wide bargaining. Employers, through merger and trade association action—and workers, through nationwide unions, are increasingly concerning themselves with welfare and health programs extending from coast to coast and from border to border.

Whether we like it or not, the future of medical practice will be shaped by great continental interests and forces. If we wish to preserve the principles of free enterprise and individual integrity in American medicine, we must look to the national spokesmen of our profession for the same bold leadership and firm support of the Blue Shield concept that the leaders of the state and county sponsoring societies have given Blue Shield during all its tender years.



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References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

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supplied: In bottles of 60 black-and-white scored tablets. Prescription only.

References: 1. Steigmann, F., **et al.:** Am. J. Gastroenterol. **33**:109 (Jan.) 1960. 2. Hock, C. W.: to be published. 3. Leming, B. H., Jr.: Clin. Med. **6**:423 (Mar.) 1959. 4. Data in Roerig Medical Department Files.

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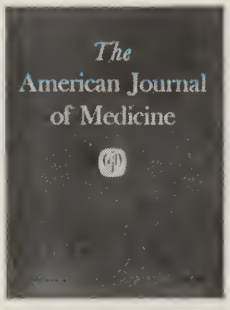
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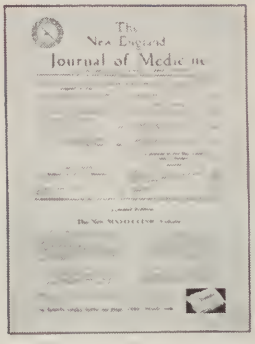
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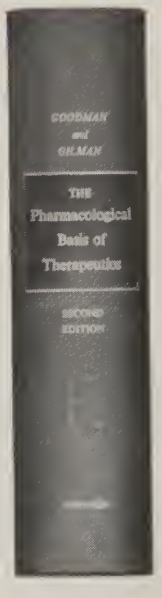
B_{12} AND FOLIC ACID

IN MULTI-VITAMINS









Individually, folic acid and B_{12} fill important clinical roles.[1] But, increasing evidence indicates that multivitamins containing folic acid may obscure the diagnosis of pernicious anemia.[2-7] And vitamin B_{12}, in indiscriminate and unnecessary usage[5-8] is likewise blamed for this diagnostic confusion.[7]

Both folic acid and B_{12} have been omitted from Adabee, in recognition of this growing medical concern. Also excluded are other factors which might interfere with concurrent therapy, such as, hormones, enzymes, amino acids, and yeast derivatives. Adabee supplies massive doses of therapeutically practical vitamins for use in both specific and supportive schedules in illness and stress situations. Thus, new Adabee offers the therapeutic advantage of sustained maximum multivitamin support without the threat of symptom-masking.

references: 1. Wintrobe, M. M., *Clinical Hematology*, 3rd ed., Phila., Lea & Febiger, 1952, p. 398. 2. Goodman, L. S. and Gilman, A., *The Pharmacological Basis of Therapeutics*, 2nd. ed., New York, Macmillan, 1955, p. 1709. 3. New Eng. J.M., Vol. 259, No. 25, Dec. 18, 1958, p. 1231. 4. Frohlich, E. D., New Eng. J.M., 259:1221, 1958. 5. J.A.M.A., 169:41, 1959. 6. J.A.M.A., 173:240, 1960. 7. Goldsmith, G. A., American J. of M., 25:680, 1958. 8. Darby, W. J., American J. of M., 25:726, 1958.

ADABEE®

Each yellow, capsule-shaped tablet contains:

Vitamin A	25,000 USP units
Vitamin D	1,000 USP units
Thiamine mononitrate (B_1)	15 mg.
Riboflavin (B_2)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Nicotinamide (niacinamide)	50 mg.
Calcium pantothenate	10 mg.
Ascorbic acid (vitamin C)	250 mg.

ADABEE® M

Each green, capsule-shaped tablet contains Adabee plus nine essential minerals:

Iron	15.0 mg.	Zinc	1.5 mg.
Iodine	0.15 mg.	Potassium	5.0 mg.
Copper	1.0 mg.	Calcium	103.0 mg.
Manganese	1.0 mg.	Phosphorus	80.0 mg.
Magnesium	6.0 mg.		

indications: As dietary supplements for the deficiency states that accompany pregnancy and lactation, surgery, burns, trauma, alcohol ingestion, hyperthyroidism, infections, cardiac disease, polyuria, anorexia, cirrhosis, arthritis, colitis, diabetes mellitus, and degenerative diseases. Also in restricted diets, particularly peptic ulcer, in geriatrics, and in concurrent administration with diuretics and antibiotics.

dosage: One or more tablets a day, as indicated, preferably with meals.

new! ADABEE®

the multivitamin without B_{12} or folic acid

A. H. ROBINS COMPANY, INC.

Richmond 20, Virginia

Blood pressure that goes up with stress often comes down with SERPASIL®

(reserpine CIBA)

One reason that many cases of hypertension respond to Serpasil is that many cases are associated with stress. Stress situations produce stimuli which pass through the sympathetic nerves, constricting blood vessels, and increasing heart rate. Hyperactivity of the sympathetic nervous system may elevate blood pressure; if prolonged, this may produce frank hypertension. By blocking the flow of excessive stimuli to the sympathetic nervous system, Serpasil guards against stress-induced vasoconstriction, brings blood pressure down slowly and gently.

In mild to moderate hypertension, Serpasil is basic therapy, effective alone "... in about 70 per cent of cases..."*

In severe hypertension, Serpasil is valuable as a primer. By adjusting the patient to the physiologic setting of lower pressure, it smooths the way for more potent antihypertensives.

In all grades of hypertension, Serpasil may be used as a background agent. By permitting lower dosage of more potent antihypertensives, Serpasil minimizes the incidence and severity of their side effects.

CIBA
SUMMIT, N. J.

*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955. /2830MB

Complete information available on request.





WASHINGTON NEWS DIGEST



Washington, D. C.—Democrats and Republicans are campaigning on opposing planks on the issue of health care for the aged. The Democratic party advocates the Social Security approach; the Republican party favors federal aid in the field, but outside the Social Security system.

The GOP plank pledged:

"Development of a health program that will provide the aged needing it, on a sound fiscal basis and through a contributory system, protection against burdensome costs of health care. Such a program should:

"—Provide the beneficiaries with the option of purchasing private health insurance—a vital distinction between our approach and Democratic proposals in that it would encourage commercial carriers and voluntary insurance organizations to continue their efforts to develop sound coverage plans for the senior population.

"—Protect the personal relationship of patient and physician.

"—Include state participation."

The Democratic Plank

The key paragraph of the Democratic plank stated:

"The most practicable way to provide health protection for older people is to use the contributory machinery of the Social Security system for insurance covering hospital bills and other high cost medical services. For those relatively few of our older people who have never been eligible for Social Security coverage, we shall provide corresponding benefits by appropriations from the general revenue."

Charles H. Percy, chairman of the GOP Platform Committee, stated that the reference to a "contributory system" in the Republican plank did not mean a Social Security tax.

Presidential and Vice Presidential candidates of both parties went into the election campaigns pledged to support the health-care-for-the-aged planks adopted by their respective conventions. Vice President Richard M. Nixon, the GOP Presidential nominee, already was on record as unalterably opposed to any program of national compulsory health insurance. The long-established position of Sen. John F. Kennedy of Massachusetts, the Democratic Presidential candidate, has been "that only by use of the Social Security system can we have true health insurance."

AMA Warns Both Parties

Speaking for the American Medical Association, Edward R. Annis, M.D., of Miami, Fla., appeared before the platform-drafting committee of the Democratic convention at Los Angeles, and Leonard W. Larson, M.D., AMA president-elect, before the Republican policy group in Chicago.

The AMA spokesmen warned both parties that a program following the Social Security approach "would be unpredictably costly, it would unnecessarily cover millions of people; it would substitute service benefits for cash benefits; it would lead to poorer—not better—quality of medical care; it would overcrowd our hospitals; it would lead to the decline, if not the demise, of private health insurance; and it would interfere dangerously with the doctor-patient relationship, which is the solid foundation upon which effective medicine must be based."

Doctor Annis also urged support of the House-approved Mills plan to provide health care for the needy aged who need help with the Federal Government and the states sharing the costs outside the Social Security mechanism.

AMA Viewpoint Outlined

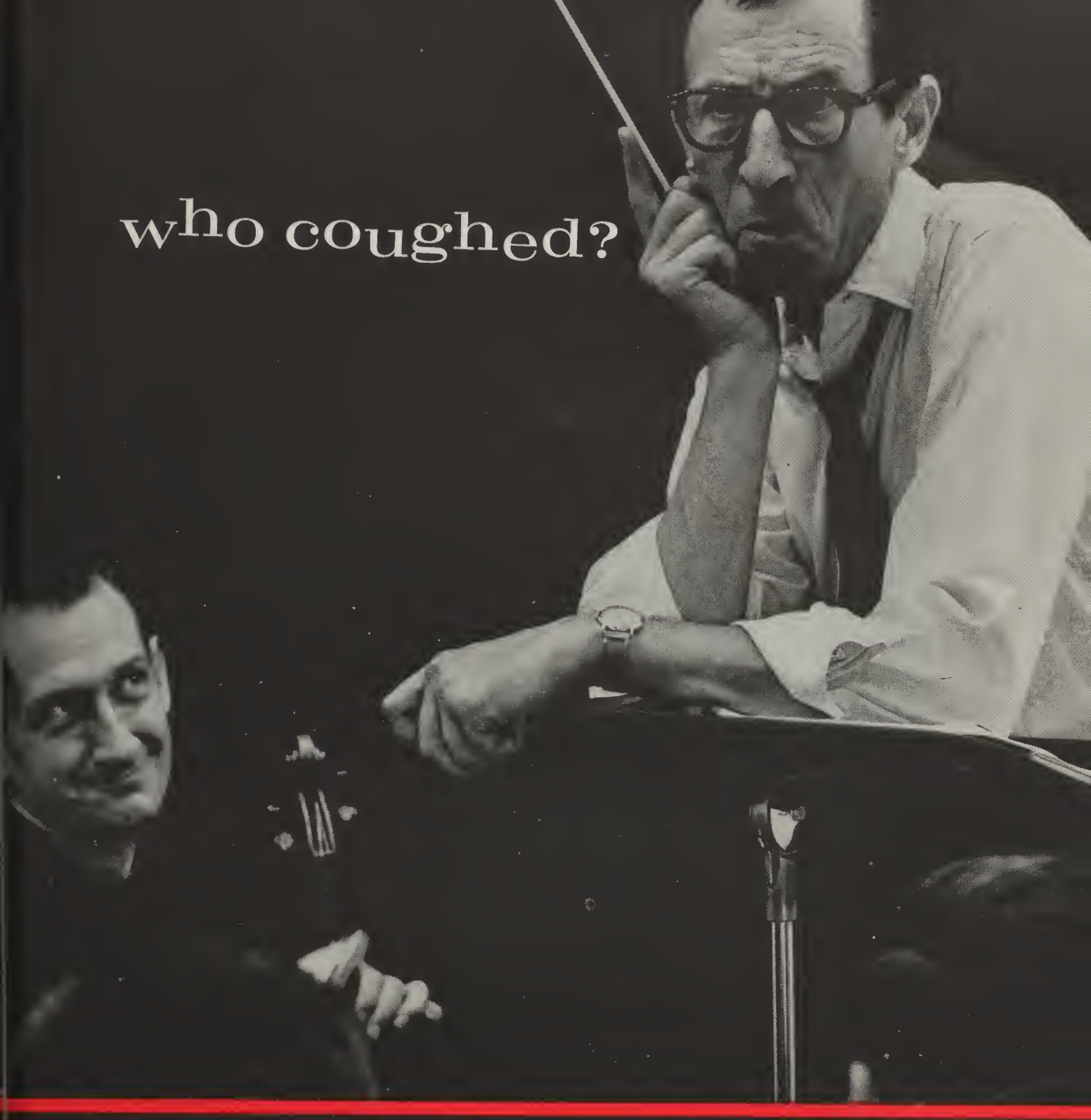
In an advertisement run in some large daily newspapers in mid-August, the AMA outlined its reasons for supporting the Mills plan. The ad said, in part:

"The AMA believes our nation, as well as its senior citizens, will best be served by a locally administered health aid program designed TO HELP THOSE WHO NEED HELP . . .

". . . We are equally sincere in our opposition to legislative measures that approach the problem on a shotgun basis—with the idea of increasing repeatedly the Social Security tax in order to finance health benefits for EVERYONE who is covered by the Old Age, Survivors and Disability Insurance program, regardless of their need.

"There are many serious hazards in using the Social Security approach to finance medical and hospital care for our older citizens. When government starts telling the doctor how to practice medicine; telling the nurses how to nurse; telling the hospital how to handle its patients, the quality of medical care is sure to decline. The cost of such a program eventually would be staggering, and would make a serious dent in the pay envelopes of millions of Americans covered by Social Security. Private, voluntary health insurance, which has been doing such a magnificent job, would be undermined and, in time, destroyed.

"Most important, perhaps, is the fact that such an approach would just be the beginning of compulsory, government-run medical care for every man, woman and child in the United States. For it wouldn't be long before the Federal Government would be lowering the age at which people would be eligible, and adding one costly service after another to a program that would place your health care under the Federal Government's thumb. And let's not forget that our present health care is recognized to be the world's finest."



WHENEVER COUGH THERAPY IS INDICATED

HYCOMINE® Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative / antihistamine
decongestant / expectorant

■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains:

Hycodan®		
Dihydrocodeinone Bitartrate	5 mg.	6.5 mg.
(Warning: May be habit-forming)		
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law permits oral prescription.

Endo®

Literature on request
ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,630,400

new clinical study[1] cites beneficial results in over 90% of cases in dry, itchy, scaly skin with Sardo®

in the bath

Use of **SARDO** in 118 dermatological patients to relieve dry, itchy, scaly, fissured skin achieved these excellent results:

CASES	AFTER SARDO*		
	Excellent	Good	Poor
49 Senile skin	32	13	4
26 Dry Skin in younger patients (diabetes, etc.)	14	11	1
20 Atopic dermatitis	8	10	2
13 Actinic changes	9	4	—
10 Ichthyosis	3	4	3
Skin Conditions	Benefited	No Benefit	
20 Nummular dermatitis	19	1	
10 Neurodermatitis	10	—	



SARDO acts[1,2] to (A) lubricate and soften skin, (B) replenish natural emollient oil, (C) prevent excessive evaporation of essential moisture.

SARDO releases millions of microfine water-miscible globules to provide a soothing suspension which enhances the efficacy of your other therapy.

SARDO is pleasant, convenient, easy to use; non-sticky, non-sensitizing. Bottles of 4, 8 and 16 oz.

for **SAMPLES** and complete reprint of Weissberg paper, please write . . .

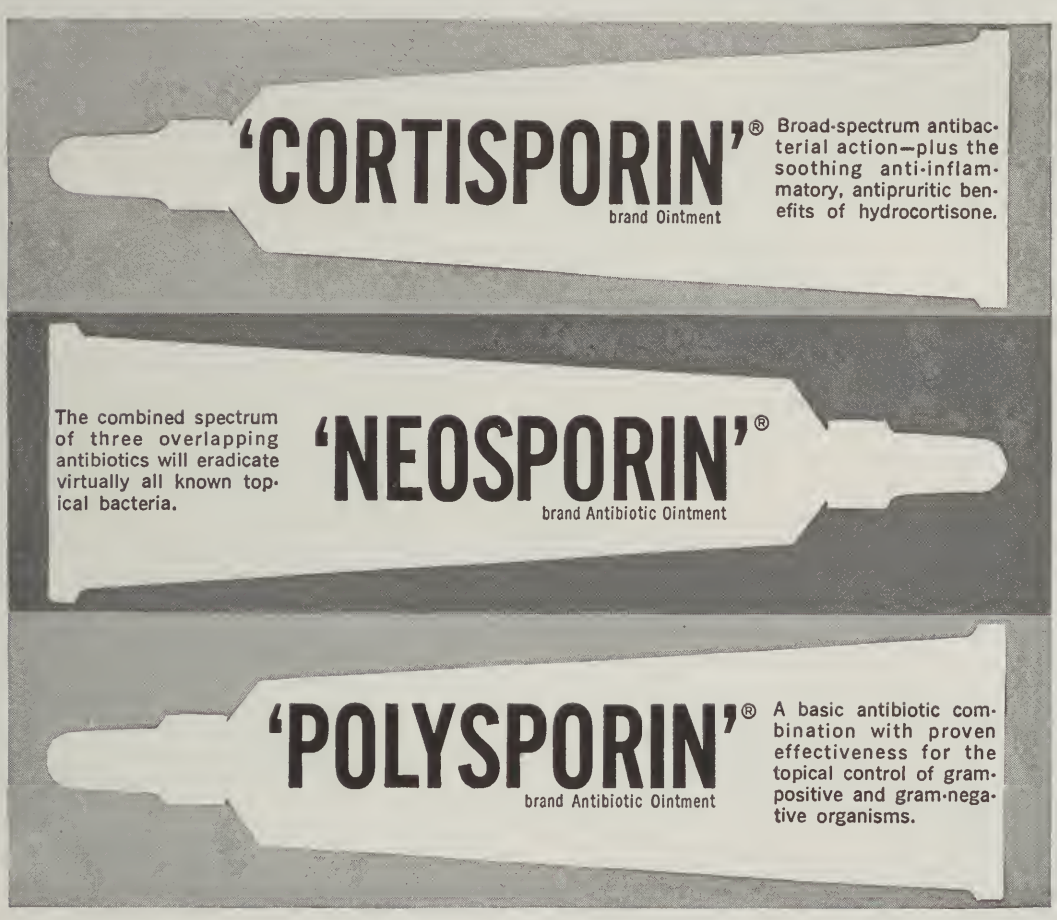
1. Weissberg, G.: Clin. Med., June 1960.

2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.

*patent pending
T.-A. ©1960

Sardeau, Inc. 75 East 55th Street, New York 22, N. Y.

'B. W. & Co.' 'Sporin' Ointments rarely sensitize . . . give decisive bactericidal action for most every topical indication



Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

extends the range of relief in HAY FEVER



usual medications act only here

NEW **isoclor** acts here to relieve both nasal and chest discomfort

NEW

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provides both . . . upper respiratory decongestion and bronchial decongestion

Many hay fever patients also experience chest discomfort. For these patients, new ISOCLOR provides relief along the entire respiratory tract.

COMBINES the nasal and bronchial decongestant action of d-isoephedrine with the histamine blocking action of chlorpheniramine.

RELIEVES the discomforts of rhinorrhea, itching, sneezing, hyperlacrimation and post nasal drip—lets the patient get a full night's rest—with minimal daytime drowsiness, CNS or pressor stimulation.

TABLETS AND SYRUP for adults and children . . .

COMPOSITION:	Per tablet	Per 5 ml. syrup
Chlorpheniramine maleate	4 mg.	2 mg.
d-Isoephedrine HCl	25 mg.	12.5 mg.

DOSE: Tablets: One tablet 3 or 4 times daily. Syrup: Children: 3-6 yrs. ½ tsp. t.i.d.; 6-12 yrs. 1 tsp. t.i.d.; Adults: 2 tsp. t.i.d.

AVAILABLE: Tablets: Bottles of 100. Syrup: Pint bottles.

ARNAR-STONE
Laboratories, Inc.
Mt. Prospect, Illinois



Doctors, too, like "Premarin"®

THE doctor's room in the hospital is used for a variety of reasons. Most any morning, you will find the internist talking with the surgeon, the resident discussing a case with the gynecologist, or the pediatrician in for a cigarette. It's sort of a club, this room, and it's a good place to get the low-down on "Premarin" therapy.

If you listen, you'll learn not only that doctors like "Premarin," but *why* they like it.

The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen. Furthermore, if the patient is suffering from headache, insomnia, and arthritic-like symptoms due to estrogen deficiency, "Premarin" takes care of that, too.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

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"be sure to make up more **TRICHOTINE** solution for our examining room."

You can see for yourself the efficient detergent action of Trichotine solution in reducing promptly a cervical plug (using a saturated cotton pledget), or washing away the "cheesy" exudate of monilia.

TRICHOTINE is just as effective for therapeutic irrigation by your patient at home

The same qualities — detergency, antisepsis, healing — make Trichotine ideal for the treatment of cervico-vaginitis and leukorrheas, alone or in conjunction with other antimicrobials. In the itching, burning, and foul odor of non-specific vaginitis and leukorrhea the action of Trichotine is immediate and gratifying to the patient.

The more you expect of a douche, the more you will use Trichotine in the office and prescribe it for home irrigation, and recommend it as well for postmenstrual and postcoital hygiene.

The modern detergent douche

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in arthritis and allied disorders

Butazolidin®
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Proved by a Decade of Experience
Confirmed by 1700 Published Reports
Attested by World-Wide Usage

Since its anti-inflammatory properties were first noted in Geigy laboratories 10 years ago, time and experience have steadily fortified the position of Butazolidin as a leading nonhormonal anti-arthritic agent. Indicated in both chronic and acute forms of arthritis, Butazolidin is noted for its striking effectiveness in relieving pain, increasing mobility and halting inflammatory change.



Butazolidin®, brand of phenylbutazone: Red, sugar-coated tablets of 100 mg. Butazolidin® Alka: Orange and white capsules containing Butazolidin 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

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What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest—considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthfu habit among your young patients — an for that matter, your patients of any ag — you'll be helping them to the fines between-meals drink there is.

Nothing has ever matched the qualit of Florida citrus—watched over as i is by a State Commission that enforce the world's highest standards for qualit in fresh, frozen, canned or cartone citrus fruits and juices.

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for the acute asthmatic attack

elixir synophylate®

(Theophylline Sodium Glycinate)

RAPID ORAL CONTROL WITHOUT G.I. IRRITATION

ELIXIR SYNOPHYLATE relieves wheezing and dyspnea in 5 to 10 minutes after a single dose. Significant blood levels are achieved in 15 minutes, persisting for at least 4 hours.

Because of its built-in buffer, theophylline sodium glycinate [SYNOPHYLATE] is "tolerated in larger doses than are possible with other theophylline preparations,"[1] including aminophylline.[1-3]

the most potent theophylline elixir available . . . may avoid need for I.V. injection

1. A. M. A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) equivalent to 0.16 Gm. (2½ gr.) Theophylline U.S.P. Supplied: Bottles of 1 pint and 1 gallon.

Literature on request.

. . . particularly useful for children

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A non-profit psychiatric institution, offering modern diagnostic and treatment procedures—insulin, electroshock, psychotherapy, occupational and recreational therapy—for nervous and mental disorders. The Hospital is located in a 75-acre tract, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation. The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

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Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

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WHY IS DIFFUSION IMPORTANT?

Because the active ingredients of a spermicidal preparation must diffuse rapidly into the seminal clot and throughout the vaginal canal to be clinically effective. Lanesta Gel offers this *dual* protection. Its four spermicidal agents quickly invade the clot to stop the main body of sperm. It spreads evenly and quickly throughout the vaginal canal—seeks out every wrinkle and fold that may offer concealment to sperm. With this rapid diffusion, your patient receives full benefit of the swift spermicidal action of Lanesta Gel — in minutes — a decisive measure in conception control.

In Lanesta Gel 7-*chloro-4-indanol,* a new, effective, nonirritating, nonallergenic spermicide, produces immediate immobilization of spermatozoa in dilution of up to 1:4,000. The addition of 10 per cent NaCl in ionic form greatly accelerates spermicidal action. Ricinoleic acid facilitates rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action — plus essential diffusion and retention of the spermicidal agents in a position where they can act upon the spermatozoa.



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Supplied: Lanesta Exquiset® . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

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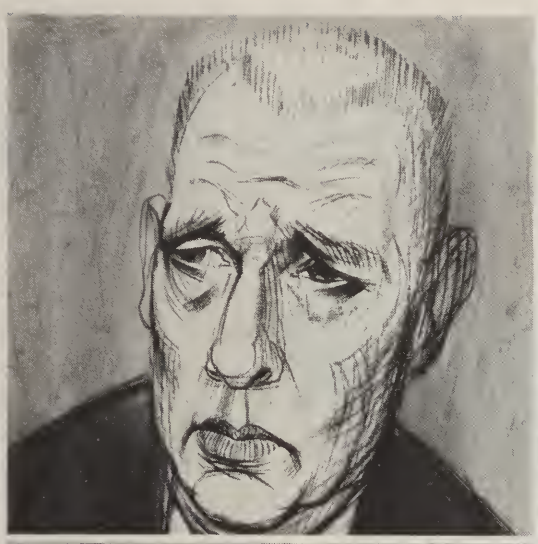
An integrated multi-therapeutic antihypertensive, that combines in balanced proportions three clinically proven antihypertensives.

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Saluron® (hydroflumethiazide)— a saluretic-antihypertensive	50 mg.
Reserpine—a tranquilizing drug with peripheral vasorelaxant effects	0.125 mg.
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whenever depression complicates the picture

Tofrānil®

brand of imipramine HCl



hastens recovery

Geigy

In many seemingly mild physical disorders an element of depression plays an insidious etiologic or complicating role.

Because of its efficacy as an antidepressant, coupled with its simplicity of usage, Tofrānil is admirably adapted to use in the home or office in these milder "depression-complicated" cases.

It is always wise to recognize that depression may be an underlying factor...that Tofrānil may speed recovery in "hypochondriasis"; in convalescence when recovery is inexplicably prolonged; in chronic illness with dejection; in the menopausal patient whose emotional disturbances resist hormone therapy; and in many other comparable situations in which latent depression may play a part.

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Tofrānil®, brand of imipramine hydrochloride, tablets of 25 mg. Ampuls for intramuscular administration, 25 mg. in 2 cc. of solution.

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In over five years

Proven
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Effective
for relief of anxiety and tension

Outstandingly Safe

1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
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3. does not produce ataxia, change in appetite or libido
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5. does not impair mental efficiency or normal behavior

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meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.
Also as MEPROTABS* — 400 mg. *unmarked,* coated tablets; and as MEPROSPAN® — 400 mg. and 200 mg. *continuous release* capsules.

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...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

"Gratifying" relief from

for your patients with
'low back syndrome' and
other musculoskeletal disorders

POTENT muscle relaxation

EFFECTIVE pain relief

SAFE for prolonged use

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study (as reported in J.A.M.A., April 30, 1960)*

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

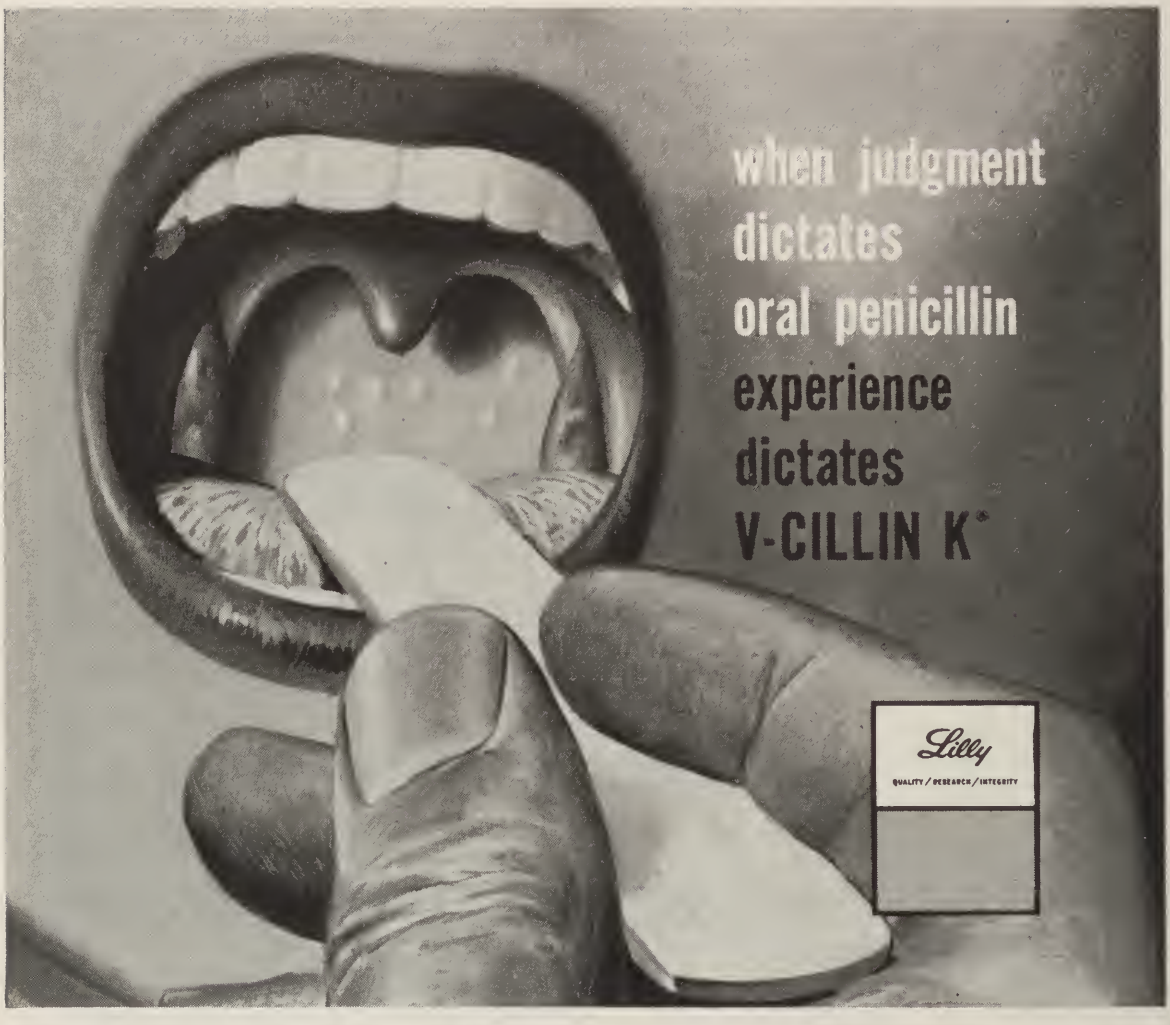
SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

SOMA®

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for maximum effectiveness Recently, Griffith[1] reported that V-Cillin K produces antibacterial activity in the serum against penicillin-sensitive pathogens which is unsurpassed by any other form of oral penicillin. This helps explain why physicians have consistently found that V-Cillin K gives a dependable clinical response.

for unmatched speed Peak levels of antibacterial activity are attained within fifteen to thirty minutes—faster than with any other oral penicillin.[1]

for unsurpassed safety The excellent safety record of V-Cillin K is well established. There is no evidence available to show that any form of penicillin is less allergenic or less toxic than V-Cillin K.

Prescribe V-Cillin K in scored tablets of 125 and 250 mg., or V-Cillin K, Pediatric, in 40 and 80-cc. bottles.

1. Griffith, R. S.: Comparison of Antibiotic Activity in Sera Following the Administration of Three Different Penicillins, Antibiotic Med. & Clin. Therapy, 7:No. 2 (February), 1960.

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The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 58 SEPTEMBER, 1960 NO. 9

The Clinical Application Of Pulmonary Function Studies*

DOUGLAS DAVID, M.D.†

Louisville, Ky.

Importance of the early recognition and definite therapy of pulmonary dysfunction is stressed here. The patient can be helped, but first he must be recognized

THE ventilatory apparatus is analogous to a mechanical system composed of an engine coupled to a pump. The engine comprises the chest wall and the diaphragm, while the pump embraces the airways and the lungs. Although the two units operate as a single assembly, their functions are distinct. The engine converts metabolic energy into mechanical work; the pump translates this work into a rhythmic exchange of air.[1]

Respiratory Movements

The walls of the thoracic cage move outward in inspiration, thus increasing the intrathoracic volume and hence effecting a suction or rise in negative pressure (10 cm. of water). Coinciding with the outward movement of the thoracic walls, there occurs a synchronous downward thrust of the diaphragm. Fully 75% of ventilation is due to diaphragmatic movement.

The expiratory phase of respiration normally is a passive act of muscular relaxation during which the chest cage falls, the diaphragm rises and there is an elastic recoil of the lung. The intrapleural pressure at this time remains at subatmospheric levels to the degree of 2.0 to 4.0 cm. of water. The elastic recoil while acting to maintain a negative pressure in the pleural space, is responsible for the production of an intrapulmonary pressure above that of the atmosphere, for the same force of shrinkage compresses and expels the air contained within the lungs. Expiration, then, is accomplished by the contractile power of the elastic connective fibers, much as inspiration is accomplished by the contractile strength of muscle fibers. The energy of expiration is primarily a function of the lung itself, that of inspiration, of diaphragmatic and intercostal musculature.

Primary Function

The primary function of the lungs is the addition of oxygen to and the removal of carbon dioxide from the venous blood.

*Presented at the Quarterly Staff Meeting of St. Joseph Infirmary on Martch 14, 1960.

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The affinity of hemoglobin for oxygen can be expressed quantitatively by the oxyhemoglobin dissociation curve, which relates the oxygen tension (physically dissolved oxygen) to the per cent of hemoglobin that is in the form of oxyhemoglobin. An increase in temperature or decrease in pH reduces the affinity of hemoglobin for oxygen. It is customary, therefore, to express the oxyhemoglobin dissociation curve at body temperature (37° C) and at a pH of 7.40, which is approximately the pH of arterial blood.

Hemoglobin which contains 1.34 cc. of oxygen per gram is entirely in the oxyhemoglobin form and is said to be fully or 100% saturated. The relationship between oxygen tension and saturation, however, is not a linear one. Above an oxygen tension of 60 mm. Hg., the curve is quite flat. (Table 1) Since the oxygen tension found normally in the pulmonary alveoli and arterial blood is above 80 mm. Hg., a considerable decrease in oxygen tension may be produced by cardiopulmonary disease, with little decrease in arterial oxygen saturation. Clinically, this is the reason when evaluating a patient for cardiopulmonary insufficiency one should speak of the partial pressure of oxygen at rest and exercise and not the chemically combined oxygen.

Pulmonary Insufficiency

The inadequate removal of carbon dioxide from the mixed venous blood is always accompanied by pulmonary insufficiency for the exchange of oxygen, unless high concentrations of 0_2 are breathed. When arterial PCO_2 rises (respiratory acidosis), the concentration of arterial H_2CO_3 and $BHCO_3$ increase and total blood CO_2 must rise. It is difficult for most physicians to accept the statement that an increased plasma (or blood) CO_2 content may occur in respiratory acidosis. Total blood CO_2 will be *high* in respiratory acidosis and metabolic alkalosis. Total blood CO_2 will be *low* in respiratory alkalosis and metabolic acidosis.

Thus, given a patient with a mixed acidosis the clinician may find a normal CO_2 content and a greatly elevated CO_2 tension.[2] Of course, the tendency of the respiratory acidosis to elevate the CO_2 content is counteracted by the opposite effect of the metabolic acidosis.

Phases of Lung Function

The major phases of lung function are as follows:

1. The *ventilation* function, or the mass exchange of air between the lungs and the atmosphere;
2. The *distribution* function, which deals with the distribution of inspired air to the alveoli;
3. The *perfusion* function, which is the distribution of mixed venous blood to the alveolar capillaries;
4. The *diffusion* function, which deals with the molecular exchange of gas across the semipermeable alveolar capillary membrane.

In recent years the application of established methods and principles of respiratory physiology has provided measures whose results may provide the physician with a pathologic physiological picture of his patient. Consequently, an accurate diagnosis of the physiological defect present may be made and more specific therapy given. Here, it should be made clear that pulmonary function tests will *not* make an etiological diagnosis but they will give one information telling where the physiological defect is located.

Ventilatory Tests

The determination of ventilatory tests provide objective measurements of the performance of the respiratory bellows. These include measurement of the vital capacity, timed vital capacity and the maximal breathing capacity. Abnormalities of ventilation may be divided into restrictive and obstructive ventilatory dysfunction. Restrictive ventilatory dysfunction is caused by any pathological process that restricts the expansion of the thoracic bellows. Obstructive ventilatory dysfunction is caused by narrowing of the air passages. Airway obstruction results in an increased resistance to air flow which is manifested by a prolongation of the time necessary for expiration. Thus the work of breathing is increased.

Ventilatory tests may be used after administration of bronchorelaxant drugs to obtain objective measurements of improvement. The pathologic physiological basis for an abnormal test usually must be defined by integrating the

results with the other aspects of the particular clinical problem. One of the most frequent uses of ventilatory tests is for quantitative assessment of ventilatory capacity in patients with chronic bronchitis or pulmonary emphysema. In some patients only minimal or equivocal abnormalities may be found by physical examination, but their ventilatory tests may clearly show the presence of an obstructive type of ventilatory abnormality.

Distribution Defects

Distribution defects lead to decreased alveolar ventilation. This can be demonstrated in the laboratory by abnormally large concentrations of nitrogen collected from the alveoli after inhalation of oxygen for seven minutes. There may be alveolar hypoventilation even though the minute volume of breathing is normal. Also one may have alveolar ventilation even though the anatomic dead space may be larger than the tidal volume. This is because of the fact that gas moves through the conducting airways as a cone front, not as a square front. Physiologically, the defect is that there is perfusion of hypoventilated alveoli. This defect is the most common mechanism of hypoxemia in pulmonary disease. If the impairment is so great that the patient cannot hyperventilate adequately (ventilate his alveoli) , hypoxemia will be associated with hypercapnia. Because the oxygen dissociation curve is not linear, regions of high ventilation/blood flow ratio do not compensate for those with a low ventilation/blood flow ratio. (Table 1)

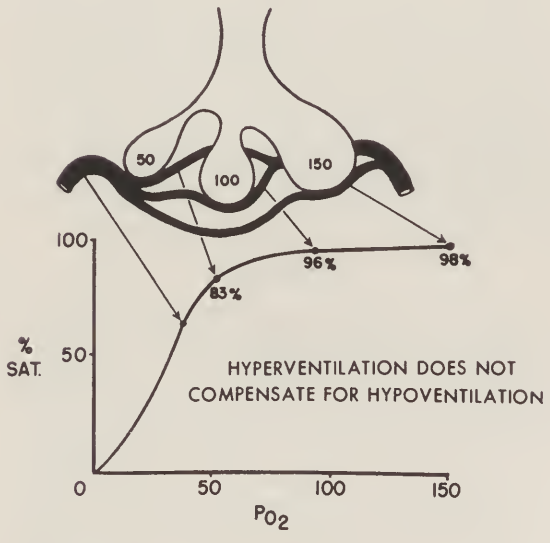
It should be stated here that the dissociation curve for CO_2 is almost linear over the physiological range, so that, one must have predominantly low ventilation/blood flow ratios over the whole lung before arterial hypercapnia exists. Clinically, this includes uneven ventilation due to bronchial obstruction (asthma, pulmonary emphysema, chronic bronchitis, organic obstruction) or to regional changes in pulmonary compliance (fibrosis, compression, infection, congestion and edema).

Pulmonary Circulation

It is just as important to know the volume and distribution of pulmonary capillary blood flow as it is to know the volume and distribution of alveolar ventilation. The lungs are supplied by a dual circulation, the pulmonary arterial and bronchial arterial systems. The pulmonary arterial tree is a low pressure system in which the mean pressure normally does not exceed 22 mm. Hg. The bronchial arteries arise from the aorta or some of its thoracic branches and contain systemic pressures. Resistance to flow in the pulmonary arterial circulation is low.

In normal man in the upright position, pressure in the pulmonary arteries remains unchanged even when the cardiac output is doubled. Soderholm[3] has occluded a pulmonary artery in a normal individual with no subsequent rise in pulmonary artery pressure. Thus

TABLE I



a marked increase in pulmonary blood flow may occur, with an increase in velocity of flow and in the caliber of the vascular bed, with little or no increase in pulmonary artery pressure. It is probable that the increase in caliber of the vascular bed is due not only to the distensibility of the individual vessels but also to the opening up of vessels which were formerly not carrying blood.

Reduction of blood flow through portions of the lung occurs very frequently in extensive chronic pulmonary disease. In some cases there is an actual anatomic narrowing or obliteration of the vascular bed due to fibrosis or destruction of capillaries as in chronic pulmonary emphysema; in other cases, localized increase in resistance to blood flow may result from local hypoxia and/or hypercapnia.[4]

Some methods for detecting uneven blood flow have been in use for years. The radiologist often makes observations on the pattern of vascular markings in the lung fields or, by pneumoangiography, determines the distribution of intravascular contrast media in the pulmonary circulation. The technique of bronchospirometry reveals how the pulmonary function is distributed between the two lungs.

Normally, 55% of the total oxygen consumption is from the right lung and 45% from the left. In the absence of hypoxia, there is a direct correlation between blood flow and differential oxygen consumption. In patients with hypoxia, however, the blood flow will be underestimated through the diseased lung. This most likely is caused by the venous admixture that has been demonstrated in cases with parenchymal lung disease. A more recent technique employs an infra-red analyzer for the continuous analysis of carbon dioxide in expired alveolar gas. This information will give one insight into the ventilation/perfusion ratio in different parts of the lung.

Diffusion

In order to enter the blood, gases must cross the alveolar epithelium, the interstitial space of the alveolar septum and the capillary endothelium. This movement occurs mainly by a process of diffusion or the movement of molecules from a region of higher to one of the lower partial pressure. The diffusing capacity of the lungs is a measure of this process. It is defined as the quantity of a gas in cubic centimeters transferred each minute per millimeter of mercury difference in partial pressure of the gas across the alveolar capillary barrier. It may be expressed as the diffusing capacity for oxygen or carbon monoxide.

The total area available for diffusion is reduced following pulmonary resection, destructive pulmonary disease, and in pulmonary fibrosis. Thickening of the alveolar capillary barrier by disease will impede the passage of oxygen into the capillary blood and so will decrease the oxygen diffusion capacity of the lung. Because of its greater solubility, carbon dioxide will be much less affected by thickening of the alveolar capillary membrane. Consequently, where the main abnormality is thickening of the membrane, severe degrees of hypoxemia may coexist with normal partial pressures of carbon dioxide in arterial blood.

The term "aveolar capillary block" has been applied to conditions in which the chief disturbance in pulmonary function is a decrease in the diffusing capacity. In these cases there is usually restrictive ventilatory dysfunction, little or no reduction of maximum breathing capacity and no abnormality of distribution of inspired air. This has been found to occur in the following diseases and conditions: beryllium granulomatosis, pulmonary sarcoidosis, pulmonary scleroderma, interstitial pulmonary fibrosis, pulmonary lymphangitic carcinomatosis, asbestosis, eosinophilic granuloma, alveolar cell carcinoma, sulfur dioxide exposure, et cetera.

Lung Volume Studies

The determination of lung volumes is often very helpful in ascertaining abnormalities of the lungs. The air remaining in the lungs when it has been maximally compressed represents the residual lung volume. When the lungs are fully extended, the air they contain represents the total lung capacity. The vital capacity is the volume of air which can be exhaled after a full inspiration. The volume of air which can be exhaled starting at the expiratory end position is known as the expiratory reserve volume. The functional residual capacity is the sum of the residual volume and expiratory reserve volume. The vital capacity minus the expiratory reserve is the inspiratory capacity. The residual volume and therefore the functional residual capacity and total lung capacity must be measured by indirect technique. All other lung compartments can be measured by simple spirometry.

Lung volume studies in restrictive ventilatory dysfunction show that the total lung capacity is reduced. The vital capacity is usually decreased proportionately to the reduction in total lung capacity. The maximum breathing capacity is relatively much larger than the vital capacity giving rise to an increased AVI (Air velocity index $\frac{\%\text{ norm. M.B.C.}}{\%\text{ norm. V.C.}}$). The residual volume and functional residual capacity may be unchanged or may be reduced proportionately much less than the total lung capacity, depending on the mechanism of the restrictive defect.

Airway obstruction results in a decreased timed vital capacity. The vital capacity may be normal or reduced, but the maximum breathing capacity is always reduced and is proportionately much smaller than the vital capacity giving rise to a decreased air velocity index. The phenomenon of air trapping and hyperinflation of the lungs is demonstrated by an increase in the residual volume and functional residual capacity.

Patients with combined restrictive and obstructive ventilatory dysfunction show a decreased timed vital capacity. Their total lung capacity is decreased, and the residual volume and functional residual capacity are increased. The air velocity index may be one or may be decreased.

Absolute shunting or the shunting of mixed venous blood around ventilated alveoli causes anoxemia. Since inhalation of oxygen cannot, under these circumstances, bring arterial blood oxygen to maximal values but does fully oxygenate the blood of patients with hypoventilation, uneven distribution or impaired diffusion, an oxygen test serves to identify the existence of venous to arterial shunts. The oxygen test proves the presence of a shunt but does not identify its type or location; it may be intrapulmonary or intracardiac.

Preoperative Evaluation

In surgical treatment of patients with bilateral lung disease, it is necessary to know how pulmonary function is distributed between the two lungs. Differential bronchospirometry at rest and with exercise gives the cardiopulmonary physiologist insight into the effect of the contemplated surgery on the total pulmonary reserve. It also aids in the selection of those patients in whom a more detailed investigation is required, but he is able to do this only by knowing what procedure is planned and whether it will place additional work on the heart and lungs or decrease the physiological stress already present.

Four indications for evaluation by the cardiopulmonary laboratory prior to pulmonary surgery are as follows:

1. Routine pulmonary function tests (including arterial blood gas analyses) are indicated in patients whose pulmonary reserve seems diminished by history and/or physical or laboratory examination. X-ray evidence of extensive lung damage is also an indication for routine assessment.
2. Bronchospirometry is desirable in those candidates for extensive lung resection (e.g., pneumonectomy or bilateral resection) who have a decrease in their pulmonary reserve as measured by routine function tests.
3. Right heart catheterization is desirable in all patients with clinical, electrocardiographic or x-ray evidence of pulmonary hypertension.
4. Pulmonary artery occlusion of the lung to be removed adds much useful information. Such "functional pneumonectomy" not only shows the ability of the remaining lesser circulation to accommodate to the increased blood flow, but also clearly demonstrates whether or not the patient can survive without that lung. It also helps to give the physician information upon which to prognosticate the degree of surgical risk and post-operative disability.

It should be made clear at this time that pulmonary function studies in the patient waiting to undergo surgery (pulmonary or general) are applied only after correlation with all available clinical, roentgenologic and physiologic data. The influence of these studies on the decisions made by the surgeon, anesthesiologist and family doctor, will greatly affect the patient's preoperative, operative and post-operative treatment. Although the availability of objective data on the pathologic cardiopulmonary physiology present and its effect on the clinical status of the patient does not completely eliminate post-operative invalidism and death due to cardiopulmonary insufficiency, it affords more certainty in the selection and treatment of surgical candidates.

Acute Pulmonary Insufficiency

Acute pulmonary insufficiency in chronic pulmonary disease is a medical emergency. Its therapy is difficult, and the mortality is great. A number of approaches to the problem have been employed, including the use of antibiotics, corticosteroids, oxygen, tracheotomy, and various mechanical devices to improve respiration.

The physiologic derangement seen in this condition is relatively constant although it may occur in a wide variety of diseases. There is severe arterial hypoxia and hypercapnia. Associated with the persistent hypercapnia is a decreased sensitivity of the respiratory center to the stimulus of carbon dioxide. The sole remaining stimulus to respiration is arterial hypoxia. When this stimulus is lost, alveolar ventilation decreases, arterial hypercapnia increases, the pH of the arterial blood decreases, and death ensues. In order to decrease the hypercapnia or minimize its increase and, at the same time, prevent severe hypoxia, oxygen in concentrations of less than 100% is used in the treatment of this condition.

Our studies tend to confirm the documented observation that relief of arterial hypoxemia with physiologic levels of arterial oxygen has little effect on minute ventilation in patients with pulmonary emphysema and carbon dioxide retention. However, a considerable increase in arterial Po_2 such as occurs with breathing high oxygen mixtures, elicits a marked decrease in minute ventilation. This suggests that it is important to distinguish between physiologic and pathophysiologic levels of oxygen tension in the arterial blood. Therefore, it is not necessary to leave a patient severely hypoxic because of fear of oxygen therapy causing apnea or alveolar hypoventilation. (Table 2)

The value of arterial oxygen studies in determining the concentration of inspired oxygen needed in the hypoxic patient cannot be overemphasized.

The increase in arterial oxygen tension to a given inspired concentration of oxygen will depend on the underlying pulmonary structural pathology present; consequently, no two patients will respond exactly alike. This is important physiologically because it stresses the necessity of varying the concentrations of inspired oxygen and of subsequently obtaining arterial samples in order to reach the point, in each patient, at which the arterial oxygen is within the physiologic range and the carbon dioxide has minimally increased or has decreased.

TABLE II

Arterial gas tensions before and after oxygen therapy

Patient	Before trial therapy Po_2* Pco_2*	Method of oxygen administration Percent Oxygen (Approximate)		After Trial therapy Po_2* Pco_2*
R.M.W.	39 62	40	IPPB/I 20 min. 12 cm. H_2O	118 76
A.T.F.	26 77	40	IPPB/I 12 min. 12 cm. H_2O	108 93
J.A.	22 73	40	IPPB/I 15 min. 18 cm. H_2O	64 100
		73	IPPB/I 15 min. 12 cm. H_2O	76 90
		100	Nasal catheter 1 hour, 8 liters per minute	49 80
M.K.	27 59	35	IPPB/I 15 min. 12 cm. H_2O	150 64
		27	IPPB/I 15 min. 12 cm. H_2O	116 69
		100	Nasal catheter 15 min., 5 liters per minute	87 63
A.F.	32 77	32	IPPB/I 15 min. 12 cm. H_2O	154 74
		27	IPPB/I 15 min. 12 cm. H_2O	140 62
J.D.	79 95 (in Oxygen Tent)		Room Air 5 min.	44 88
		100	Nasal catheter 15 min. ½ L./min.	56 79

*Arterial oxygen and carbon dioxide tensions in millimeters of mercury.

Arterial hypoxia of cardiopulmonary origin can occur only because of:

1. Alveolar hypoventilation,
   A) Secondary to disease of the lungs, chest wall or neuromuscular apparatus, and,
   B) Primary (due to repression of respiratory center);
2. Uneven alveolar ventilation in relation to pulmonary capillary blood flow;
3. Impairment of alveolar capillary diffusion;
4. Right - to - left shunts.

Arterial hypoxia can occur in other conditions (high altitude breathing, inspiration of low oxygen mixtures, hemoglobinopathies), but these are not of cardiopulmonary origin and will not be discussed here. Cyanosis (without arterial hypoxia) can occur because of reduction in blood flow to a metabolically active part, resulting in the extraction of greater than normal amounts of oxygen from each unit of blood. Since this is not arterial hypoxia, it will not be discussed here.

Primary Alveolar Hypoventilation

Primary alveolar hypoventilation is due to depression of the respiratory center in the medulla. As far as we know the anatomical site has not been localized. The most prominent clinical feature of patients with the primary hypoventilation syndrome is polycythemia. The presence of CO_2 retention in association with arterial hypoxia rules out both a right-to-left shunt and a diffusion defect. If a distribution defect is ruled out then the differentiation between primary and secondary polycythemia is made less difficult.

The presence of leukocytosis, thrombocytosis and splenomegaly may suggest that the hematologic problem is a primary one, but one must keep in mind that polycythemia vera and certain tumors may be found with an associated polycythemia and no increase in other blood constituents. Ratto[5] has reported anoxemia secondary to polycythemia vera. He and his associates postulated vascular thromboses in the brain stem of their patient. The decreased sensitivity of the respiratory center is established by the administration of 7.5% CO_2 to a patient. Quantitative evaluation of the ventilatory response to CO_2 must be related to changes in arterial Pco_2 rather than to concentration of CO_2 administered.[6] Unless pulmonary function studies are performed, cases of primary polycythemia vera will be misdiagnosed as secondary polycythemia and cases of primary hypoventilation syndrome will be misdiagnosed as primary polycythemia.

In conclusion, it is well recognized that a physician cannot observe a patient and tell at all times whether he is hypoxic and/or hypercapneic. As has been stated, this may be important not only from the diagnostic standpoint but for future therapy.

Many clinicians frequently think of pulmonary function testing in terms of an elaborate methodology, intricate calculations and obscure terminology. Although it is perfectly true that many aspects of pulmonary physiology are difficult to comprehend, there are several tests of pulmonary function with proved practical value that are basically simple to use and understand. Equally important, they can be fitted into a scheme that unifies the test results into an integrated physiological picture of the patient.

Summary

The importance of obtaining pulmonary function studies in the management of medical and surgical patients with pulmonary insufficiency has been presented. Arterial blood gas tensions have been stressed for their value not only in narrowing the differential diagnosis but also as a guide in therapy. Indications for evaluation by the cardiopulmonary laboratory prior to surgery have been discussed.

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Oral Hypoglycemic Agents And The Newer Insulins*

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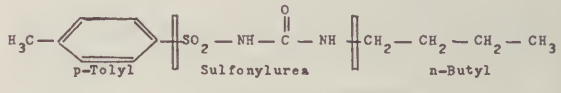
Lexington, Ky.

Oral agents are distinctly useful in at least 10 per cent of the diabetic population, but are probably being overused because of their convenience. Advantages of lente insulins cited

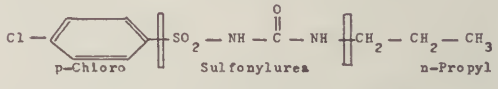
THE fascinating factors of chance and providence enter into the evolution of medicine much as they do all other phases of history. The hypoglycemic sulfonamides, which are as well known today as penicillin, came to our attention in much the same accidental way. Just as Fleming's work was interfered with by a mold, so Janbon's work in France was interrupted by a newer sulfonamide that produced the symptoms and signs of hypoglycemia.[1] Janbon, in 1942, was looking for a treatment for typhoid fever. When he found his patients developing hypoglycemia, he asked the physiologist Loubatieres for an explanation. Thus this chance observation resulted in seventeen years of research and in the development of an oral agent for the treatment of diabetes that has established itself in the clinical management of this disease.

The mechanism of the hypoglycemic action of the sulfonylureas has been established to a certain point.[2,3] The presence of the pancreas is fundamental to their action. There is strong evidence to suggest that these agents cause the release of insulin by the B-cells in the islets of Langerhans. This primary action suggests that they would have all the peripheral effects of insulin. Yet a fundamental action of insulin, i.e., an increase in the uptake of glucose by peripheral tissues, is not duplicated by these oral agents.

However, these agents do not release large quantities of insulin from the pancreas, and it may well be that the small amount of insulin released is bound up by the liver, reaching peripheral tissues in such small quantities that our crude assays fail to detect it. A second action of these agents is probably within the liver, where they inhibit glucose production or output. A third mechanism of action, which is less predictable but occasionally proves of value in cases of insulin resistance, is a potentiating effect on exogenous insulin.



1-n-Butyl-3-p-tolylsulfonylurea
(Tolbutamide)



1-n-propyl-3-p-chlorosulfonylurea
(Chlorpropamide)

Figure 1

Structural formulas of sulfonylurea compounds.

It would be difficult to argue that these drugs are entirely unphysiologic in their action. If such were the case, other abnormal consequences would now become apparent with their widespread use. They are sulfonamides, however, and as a chemical group can produce untoward side effects. (figure 1.)

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Certain dictums have laid down by experience in the use of the sulfonylureas. These are based mainly on the fact that these agents are far less potent than insulin and require the presence of insulin or functioning islets in the pancreas for their action. Therefore, their use should be reserved for the stable diabetic (usually over age 40) who cannot be controlled by diet alone. The younger or juvenile diabetic soon loses all of his islet reserve, and it is foolhardy to attempt even temporary control by the use of these agents.

Because insulin has proved itself and is virtually foolproof in the stable diabetic, oral agents should not be used unless they exert chemical control on the diabetes that is in every way equal or superior to the control by insulin. In other words, convenience of administration should never lower standards of treatment. If the use of the sulfonylureas is thus restricted, these agents probably will be needed in only 10 per cent of diabetics. Such idealism seldom is achieved, and all of us are aware that far more than this percentage of diabetics are receiving these drugs, partly because of patients' insistence, partly because of patients who will not reduce or follow their diets, and partly because of doctors who are satisfied with less than adequate control.

Side Reactions

The side reactions to these drugs, as well as their indications, will limit their clinical usefulness. Already carbutamide (1956) and metahexamide (1959) have been withdrawn from clinical trial in the United States after the Eli Lilly Company had spent close to two million dollars in their development. Both of these potent hypoglycemic sulfonamides caused a number of blood dyscrasias, cases of jaundice, and even deaths. Only two sulfonylureas have withstood the test of time. Of these two, Tolbutamide or Orinase* is the safer. Dr. O'Donovan of the Upjohn Company has a file on 9,168 cases treated with this drug with only one fatality.[4] The incidence of side reactions was 3.2 per cent, and only a small percentage of these were serious. Experience with the other sulfonylurea, chlorpropamide or Diabinese** has been documented on 5,000 patients, with two deaths and 17 cases of jaundice. The incidence of all side reactions was about 8 per cent.†

How do these two sulfonamides fit into clinical practice? I have reviewed a series of 100 consecutive diabetics seen at the Lexington Clinic during the last two years. This, unfortunately, does not represent the idealistic approach but the realistic approach, and table 1 may give you some idea of present trends.

Tolbutamide (Orinase)

Orinase is the safest, simplest agent now available and should be the first choice among oral agents. In the stable diabetic who has never been in acidosis and yet cannot achieve a normal fasting blood sugar level by diet alone, Orinase may be tried.

A simple, practical Orinase tolerance test will decide quickly whether the patient is a good candidate for this drug. This test is performed as follows: 1. No insulin except regular insulin is given for 48 hours before the test. 2. Blood for determination of fasting blood sugar is drawn. 3. Three grams of Orinase are given immediately after the blood has been drawn. 4. The patient fasts for four hours, and then a repeated blood sample is drawn and the test concluded.

If the fasting blood sugar level is elevated and the blood sugar level four hours after Orinase is within the normal range, the patient can be expected to respond to Orinase. Although this test may eliminate many patients who show some response to Orinase, it also will reduce the large number of secondary failures reported by some authors. To date, the incidence of secondary Orinase failures among patients who met these criteria has been only 5 or 6 per cent.

The usual dosage program is 2 gm. of Orinase the second day and thereafter 1 gm. daily in divided doses. Nothing is gained by a daily dose in excess of 2 gm. Since the effective half-life of Orinase is only six hours, it is reasonable to divide the total daily dose into two doses.[5]

We encountered only two serious reactions

Orinase is the trade name of the Upjohn Company for Tolbutamide.

***Diabinese is the trade name of Pfizer Laboratories for chlorpropamide.*

†*Data courtesy of Robert Warner, M.D., Pfizer Laboratories, Brooklyn, N. Y.*

in all of our patients treated with Orinase. One patient developed aplastic anemia, which diagnosis had been made at the Mayo Clinic before the patient was referred to us. The other patient, who was known to have cirrhosis previously, developed jaundice. The Council on Drugs of the American Medical Association has on record six cases in which Orinase was associated with a blood dyscrasia. It was reported that in five of these six cases Orinase was the only substance that had been taken by the patient, and two of these patients died.[6]

The combining of insulin with Orinase has not proved fruitful in our experience or that of most other observers. However, such a combination has proved of value in rare cases of insulin resistance, in which over 200 units of insulin daily are required.

TABLE I
Treatment of
100 Consecutive Diabetics
(1957-1959)

Diet alone	26
Insulin	48
Orinase	18
Diabinese	8

Chlorpropamide (Diabinese)

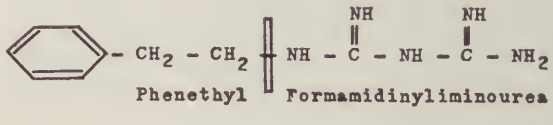
Diabinese is a more potent but more toxic hypoglycemic agent than Orinase. It should be used only in the treatment of stable diabetics who have not responded to Orinase. Unfortunately, the number of patients who respond to Diabinese after having failed to respond to Orinase is small.

There is no practical Diabinese tolerance test, because this drug's action is slow and cumulative. The cumulative effect of Diabinese may be compared with that of digitalis and is the result of its effective half-life of 36 hours.[5] For this reason Diabinese must be used with caution in patients who are elderly or whose kidneys function poorly.

There have been hypoglycemic fatalities and many cases of coma because physicians who were more accustomed to Orinase employed Diabinese in a similar dose range. At least four or five days are required to judge the effect of a certain daily dose of Diabinese. Its prolonged effect allows the advantage of a single daily dose, which varies from 50 to 500 mg. A good plan for initial therapy would be to start with 250 mg. daily and adjust the daily dose downward or upward, according to the patient's fasting blood sugar level, on a weekly basis. With either sulfonylurea drug, but especially with Diabinese, a complete blood count, a urinalysis, and a few simple liver function tests should be done about two to four weeks after initiation of therapy.

For over a year I have been studying the effect of Diabinese on 12 patients, whose course is being carefully followed. Monthly blood counts and liver function tests have been performed in these cases. The drug was discontinued in two patients because of abnormalities in their blood counts. One of them developed an unexplained anemia and neutropenia and the other developed neutropenia. Most of these patients have shown temporary elevations of the alkaline phosphatase level, but none developed clinical jaundice. Nevertheless, since the reported incidence of jaundice in almost 1 in every 300 cases, I do not believe Diabinese should be given to a patient with known liver disease.

We at the Lexington Clinic have abandoned the use of oral hypoglycemic agents in emergency situations, such as surgery, and have almost routinely substituted insulin. Even though a few persons with mild diabetes can tolerate surgery while receiving oral hypoglycemic agents, the results are unpredictable and in the hospital the use of insulin has proved more convenient and its effects are more certain.



• 2: N^1-β-phenethylbiguanide hydrochloride (DBI)

Figure 2
N^1-B-phenethylbiguanide hydrochloride (DBI).

Phenethylbiguanide (D B I) (figure 2) is an oral hypoglycemic agent with an entirely different mode of action from the hypoglycemic sulfonamides.[7] It does not lower the blood sugar level even in normal subjects. A chemically related compound, synthaline, was tried over 30 years ago, but its use was abandoned following

reports of hepatic toxicity and the obvious effectiveness of insulin. D B I effects maximum reduction in blood sugar level in five to six hours, but the blood sugar returns to its previous level in about 10 hours. Its action is dependent not on the pancreas but chiefly on its effect on peripheral tissues.

Since there is an increase in the uptake of glucose by muscle and yet no increase in oxygen consumption, it has been postulated that D B I acts through a process of anaerobic glycolysis. This correlates with an associated accumulation of lactic acid. In other words, the primary action is the inhibition of certain oxidative enzymes. In this way the drug might act on peripheral tissues as well as decrease gluconeogenesis in the liver.

Phenethylbiguanide (D. B. I.)*

From the results of this basic study one might speculate that D B I is really a protoplasmic poison, but in over two years of clinical trial no cases of severe toxicity have been reported. There has been a high incidence of nausea and vomiting,[8] varying from 20 to 50 per cent. Perhaps this side effect, which limits the drug's clinical usefulness, might also limit its toxicity. Other disagreeable side effects include weakness and lassitude and an unpleasant taste in the mouth. It should be emphasized, however, that unlike the experience with the sulfonylureas, no jaundice, blood dyscrasias, or other severe toxic reactions to D B I have been reported.

Because of the high incidence of gastrointestinal side effects, D B I alone would seem to be of little value in the treatment of the obese or stable diabetic. In the juvenile diabetic it may replace insulin for a year or two, but insulin will invariably be added later. Because of these facts, much of the clinical work with D B I has been directed toward using it in combination with insulin to help stabilize and improve the control of the young "brittle" diabetic suffering frequent insulin reactions. Perhaps the schematic diagram in figure 3 will help to illustrate how D B I fits into the treatment of diabetes thus far. Since the mechanisms of action of the sulfonylureas and D B I are quite different, they can be used together occasionally with an additive effect.[9]

Ordinarily, in young diabetics beginning D B I therapy, the use of insulin may be continued while the effect of one tablet (25 mg.) two or three times daily (with meals) is observed. The dose of insulin may be decreased gradually, by 10 per cent decrements, after treatment with D B I has been started. In the more stable patients, insulin may be discontinued and D B I, one tablet (25 mg.), may be given with meals and at bedtime (100 mg. per day). If nausea and vomiting occur that day, the dose may be reduced the next day. If necessary to

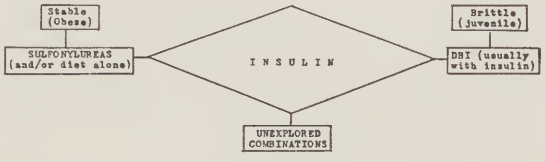


Figure 3

Agents employed in treatment of diabetes (from the mild to the severe).

effect control, up to 150 mg. daily may be used; but this is the practical upper limit of dosage because of the gastrointestinal side effects. Since the effect of a dose without insulin may be dissipated in 10 hours, a blood sugar determination two or three hours after eating, rather than one after fasting, will better evaluate the drug's action.

Another disturbing finding in patients under treatment with D B I may be acetone in the urine, despite a normal blood sugar level and no glycosuria. This effect may be analagous to "starvation ketosis." In any event, it often is eliminated by reducing the dose of D B I (and slightly increasing the dose of insulin, if both agents are being used). Of all oral hypoglycemic agents, D B I is the most difficult to use and requires the closest dosage adjustment.

Insulin Modifications

Insulin remains the most effective agent in the treatment of diabetes, and it is only because of insulin's "inconvenience" that the oral hypoglycemic agents have been considered. Therefore, it seems fitting to review some of the work with the newer modifications of insulin.

In 1952 Hallas-Moller and his group[10] in

**DBI is trade name of U.S. Vitamin & Pharmaceutical Corp. for Phenethylbiguanide.*

Copenhagen found that a simple change in the buffering agent of zinc insulin would allow a prolongation of its effect without the addition of protamine. This, of course, simplifies the production of zinc insulin and avoids the possibility of sensitivity to the protamine molecule.

Further experimentation with this zinc insulin complex in an *acetate* buffer proved that variations of timing could be achieved by simply varying the pH. For a quick and short acting insulin, we already have become accustomed to the use of unmodified insulin or crystalline insulin containing zinc. For a somewhat longer effect, the further addition of 2 mg. of zinc per 1,000 units of *amorphous* insulin produces a cloudy suspension known as semi-lente insulin. Its absorption makes it intermediate in duration of action between regular insulin and the well-known NPH insulin. When a neutral suspension of *crystalline* insulin with the same amount of zinc is made, a very long and slow acting insulin is produced, which is known as ultra-lente.

A product known as lente insulin was first marketed in this country in 1954; it is a combination of seven parts of ultra-lente and three parts of semi-lente.[11] This lente insulin has a time action almost identical to that of NPH insulin but avoids the addition of protamine, to which a few patients may be sensitive. The characteristics of the newer insulins are shown in table 2.

In view of the confusing number of insulins now available, it would seem wise to begin all new diabetics on therapy with lente insulin in the hope that some day the production of globin, NPH, and PZI can be abandoned. Lente insulin alone is effective in the vast majority of patients. In the 10 to 15 per cent brittle diabetics, whose disease is more difficult to control, a two-dose program usually is necessary. In an attempt to avoid two daily doses, the entire lente insulin triad has been made available, so that individualized or "tailor made" mixtures are possible.

Semi-lente, lente, and ultra-lente insulins can be mixed in the same syringe in any combination desired. Whenever lente insulin alone fails to give an adequate 24-hour effect or does not prevent postbreakfast hyperglycemia, a small amount of ultra-lente may be added to the lente insulin. This permits 24-hour control with one morning injection, eliminating the inconvenience of a second injection in the evening. Similarly, when lente insulin alone produces a normal fasting blood sugar level but allows excessive hyperglycemia during the day, a small amount of semi-lente insulin may be added for its quick effect. Some physicians prefer to add regular insulin to lente insulin for this effect. Although the two insulins have different buffering agents, the combination of lente and regular insulins is satisfactory if the amount of regular insulin does not exceed a third of the total dose.

Two Cases Given

Since lente insulin itself is simply a mixture of seven parts of ultra-lente with three parts of semi-lente insulin, therapy in difficult cases can be adjusted with the use of a combination better fitted for the patient's individual need. This point is illustrated by the following summaries of two cases in which mixtures of ultra-lente and semi-lente insulins were used:

CASE 1.—The patient, age 26, was poorly controlled on a combination of NPH and regular insulin, since his fasting blood sugar levels were too high, and attempts to increase the dose of NPH caused too many daytime insulin

TABLE 2

Characteristics of Newer Insulins

Type	Appearance	Action	Duration (hours)	Buffer	Protein
NPH	Turbid	Slow	24-28	Phosphate	Protamine
Lente	Turbid	Slow	24-28	Acetate	None
Semi-Lente	Turbid	Rapid	12-16	Acetate	None
Ultra-Lente	Turbid	Very slow	24-36+	Acetate	None

reactions. The patient wished to avoid a two-dose program. Since lente (or NPH insulin) did not seem to give an adequate 24-hour effect, we increased the proportion of ultra-lente in his mixture, so that he took four parts (40 units) of ultra-lente to one part (10 units) of semi-lente, instead of the usual 7:3 ratio. On this program the fasting blood sugar levels became normal or nearly normal and the patient had no significant daytime insulin reactions.

CASE 2. — The patient was a 29-year-old farmer who was very active and, in maintaining good diabetic control on NPH insulin was suffering too many daytime reactions. Part of this difficulty was corrected by a midmorning and midafternoon snack during workdays, but a slower acting insulin was needed. A combination of ultra-lente and semi-lente insulins in the ratio of 4:1 (a total of 52 units) was used instead of the 55 units of NPH previously employed. The fasting blood sugar levels remained normal and daytime insulin reactions were no longer a problem.

Obviously, adjustments with this combination can be made easily from time to time. If more daytime effect is desired, the proportion of semi-lente insulin is increased. If less daytime effect (and more nighttime effect) is needed, the proportion of semi-lente insulin is decreased. The total dose of the mixture used is usually the same as the dose of lente or NPH that was previously employed.

It should be emphasized again that for 90 per cent of diabetics requiring insulin a single dose of lente insulin is satisfactory. The remaining 10 per cent will need a two-dose program or some combination of the lente insulin triad. It should be emphasized again, also, that although this triad can be mixed in any proportion desired, they cannot be mixed with other modified insulins, such as PZI, NPH, or globin insulin.

Summary

Although the hypoglycemic action of the sulfonylurea drugs has been known for 17 years, only two of these compounds have withstood the rigors of clinical trial. One of these, tolbutamide (Orinase), should be given first choice because of its relative safety. The other, chlorpropamide (Diabinese), is more potent, at the expense of increased toxicity. A third oral agent, phenethylbiguanide (DBI), produces hypoglycemia by an entirely different mode of action. Its use has been limited by gastrointestinal side effects. In smaller dosage it has been used effectively in combination with either insulin or the sulfonylurea drugs. The majority of diabetics still require treatment by diet or by diet plus insulin.

Newer modifications of zinc insulin have resulted in a prolongation of its effect without the addition of protamine. These zinc insulin suspensions are marked as semi-lente, ultra-lente, and as a combination called lente. They can be mixed in any proportion desired for a "tailor made" effect. The combination marketed as lente insulin has a time action similar to that of NPH insulin and a single daily injection is satisfactory for 90 per cent of diabetics who require insulin. The remaining 10 per cent require a two-dose program or some combination of the lente triad.

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Toxoplasmosis*

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A disease infrequently considered and reported is reviewed, with the presentation of three cases found in the Pikeville area. Four signs of the clinical forms are given

THREE proved cases of toxoplasmosis have been diagnosed in the Pikeville area in the past five years. It is felt that a review of the literature and report of these cases would prove beneficial. The Kentucky State Department of Health does not include toxoplasmosis as a reportable disease; therefore, I must assume that no cases have been reported or those reported have not been made a matter of record. The fact that 26 serum samples were submitted for study for toxoplasmosis in 1959 is evidence that many of the doctors in our State are considering this disease seriously in their differential diagnosis.

Many authors have contributed to the literature on toxoplasmosis, but Albert B. Sabin, M. D.[1] of Cincinnati, Ohio, and J. K. Frenkel, M. D.[2] of the University of California Medical School have presented the best coverage of the entire disease. Most of the information in this paper is gathered from their reports.

Toxoplasmosis has been known to be pathological in animals and rodents for many years. It was not until 1923 that Janku described a well authenticated case in a human being in Czechoslovakia. Since then cases have been reported from all parts of the world. In 1937, Wolf and Cowen reported the first case in the United States. At the time of Frenkel's report in 1949, only 35 cases of toxoplasmosis had been reported in the literature.[2]

*Presented before the Pike County Medical Society on January 19, 1960.

The Toxoplasma

"Toxoplasma are highly organized protozoan parasites with distinct cytoplasm and nuclear chromatin. Their size and shape vary with the stage of development and the mode of examination. In the fresh state, as in the examination of a hanging drop or a cover slip preparation of an exudate containing toxoplasma or in Giemsa or Wright stained air dried films, they vary in size from 4 to 7 u in length and about 2 to 4 u in width. Multiplication occurs by binary fission and there is no good evidence that schizogony takes place.

"A recently divided toxoplasma is crescentic in shape with one end pointed and the other slightly rounded. There is no nuclear membrane and the nuclear chromatin often constitutes about a third of the parasite. No flagella or outer membranes are present and there is no evidence of active propelling motion other than the movement of the pointed end in various planes that is seen in fresh preparations. As the toxoplasma grows, it loses its crescentic shape and becomes pyriform, oval or round, prior to division in the longitudinal plane."[1]

Transmission

Apparently toxoplasmosis is transmitted to humans from infected animals. Almost all the lower animals have been found capable of carrying the protozoan. The method of transmission is not known, but experimentally it has been accomplished by all routes. The blood of an infected animal will infect a well animal; therefore, it could be carried by blood sucking insects. Well animals that eat the flesh of diseased ones will develop the disease. The urine and feces of infected dogs and cats might be another means of transmission to humans.[1] Eichenwald showed that the toxoplasma could be transmitted through the milk of infected mice to non-infected mice.[3]

Clinically, toxoplasmosis presents itself in

many different forms due to the variation in the virulence of the strain and the variation in the resistance of the host. Also complicating the clinical picture is the different way toxoplasma are acquired. There is no doubt that there is transplacental infection since most cases are dead at birth or die soon after birth with demonstrable toxoplasma infections and with high maternal antibody titres. No doubt many of the congenital infections survive and later present clinical signs and symptoms. There is little doubt that some cases are acquired by infection with the organism later in life.

Frenkel has made an excellent outline of the characteristics of the different clinical forms: (1) congenital or neonatal meningoencephalitis, usually associated with hydrocephaly, chorioretinitis, cerebral calcifications and convulsions; (2) atypical encephalitis; (3) post encephalitis sequelae, or (4) pneumonitis associated with fever and rash.[2]

The Congenital Form

The most common form of toxoplasmosis seen is the congenital. Apparently the mother has become infected by the organism sometime prior to pregnancy or during pregnancy, then the toxoplasma is transmitted through the placenta to the fetus. Due to the fact that the organism is transmitted through the blood stream, the transmission to the fetus might be from the initial infection or it might be from the rupture of one of the pseudocysts typically found in chronic infections.

It is conceivable that the mother could have had the infection for many years in a chronic and asymptomatic stage. It is in these chronic cases that the toxoplasma are found in cysts or pseudocysts which might rupture at any time and cause dissemination through the blood stream. This might conceivably cause reactivation of the disease in the mother or by transplacental infection cause toxoplasmosis in the fetus. Most cases of congenital toxoplasmosis die in utero or shortly after birth; but some of them recover and present evidence of their disease later.

Due to the preference of toxoplasma for tissue of neuroectodermal origin, there is characteristically found extensive destruction of the tissue of the central nervous system. Sabin describes the tetrad of internal hydocephaly or mirocephaly, chorioretinitis with a special predilection for the macular regions, convulsions (or other signs of involvement of the central nervous system) and roentgen evidence of cerebral calcifications.[1] All the above may be present in a typical case, but in some cases, some of the tetrad may be absent.

When confronted by any of the signs of toxoplasmosis in a dead fetus, the diagnosis may be confirmed by post-mortem demonstration of the organism in infected tissue. Since the organism has a predilection for the periventricular area and the retina, it is most easily demonstrated in tissue or fluid from these regions. Frenkel[2] has had good success in demonstrating toxoplasma in fluid taken from the ventricular space.[2] In the living infant showing any of the signs described above, the diagnosis may be confirmed by demonstration of toxoplasmic antibodies in the infant and the mother.

The Acquired Form

Acquired toxoplasmosis usually occurs as an acute encephalitis or as a pneumonia associated with a skin rash. The encephalitis is characterized by headache, convulsions, disorientation, coma, almost constant twitching of isolated muscle groups and a marked rise in temperature. Not infrequently toxoplasma can be demonstrated by animal inoculation with the patient's spinal fluid and in some cases toxoplasmic neutralizing antibodies can be demonstrated. There is nothing atypical about the pneumonia of acquired toxoplasmosis but the skin rash is maculopapular, bright red to pale pink and covers the entire body except the palms, soles and scalp. Sabin describes the rash as like that of Rocky Mountain spotted fever except for the distribution.

Undoubtedly, many cases of acquired toxoplasmosis recover and later show signs and symptoms of the disease in the central nervous system. It is this group as well as the congenital type that has recovered that is seen by the ophthalmologist later, complaining of visual changes. It is at this time that the oculist sees the typical chorioretinitis involving the macular area and suspects toxoplasmosis.

Treatment

There is no specific treatment for toxoplasmosis. The sulfonamides, with the exception of sulfanilamide, have shown good results in controlling the progress of the disease. It is felt that the acute cases should be treated for two to three weeks with sulfadiazine or sulfamerazine in full doses. This allows the patient time to develop antibodies enough to prevent a relapse. The treatment with sulfonamides suppresses the proliferation of the organism; but does not kill the toxoplasma.[2] It might be well to continue treatment longer since the toxoplasma persist in the host in the form of pseudocysts within the neural tissue and on the discontinuation of the sulfonamide might resume multiplication and reinfect the host. Among the drugs listed by Frenkel as ineffective are penicillin, streptomycin, chloromycetin, aureomycin, subtilin, polymyxin-B, chlorguanide hydrochloride, bacitracin, p-aminosalicylic acid, nicotinic acid and nitrofurazone.

Case Reports

CASE 1. (B. C.)—This 11-year-old white male was seen with the symptom of sudden onset of convulsions of a grand mal type. Past history was negative except for frequent headaches. There was no history in keeping with acquired infection. Entire physical examination was negative except for chorioretinitis without evidence of activity. The examiner was still not suspicious of toxoplasmosis, but ordered routine x-ray skull plates. The radiologist, Dr. Gene N. Combs, at the Methodist Hospital reported calcifications typical of toxoplasmosis (Fig. 1.). The patient was also referred to Dr. C. F. Wilson, opthalmologist, who confirmed the chorioretinitis as typical toxoplasmosis. Having heard Dr. James Hughes of Memphis, Tenn. lecture at one of our KSMA meetings, I referred this boy to him for confirmation. He concurred in the diagnosis.

This patient was treated with Daraprim® and sulfadiazine along with anticonvulsive therapy. He has had no ocular or neurological change in five years. Examination of the mother was negative for any evidence of the disease.

CASE 2. (J. E.)—This 12-year-old white male patient was referred to my service by



Cerebral calcifications typical of toxoplasmosis are shown in these X-ray skull plates of 11-year-old male.



Dr. C. F. Wilson for study for toxoplasmosis. He had gone to Dr. Wilson because of sudden onset of blurred vision without previous symptoms. Fundiscopic study showed both old chorioretinitis and fresh retinal edema. This is very interesting in that it is typical of cases reported by Frenkel in which pseudocysts of old disease rupture causing acute disease. Entire work-up was negative; but feeling that this was typical toxoplasmosis, I referred this case to Dr. James Hughes in Memphis, who con-

curred in the diagnosis. Before being sent to Memphis, and on consultation with Dr. Wilson, this patient was started on routine treatment along with cortical steroids (Sterane®). He responded well and he has had no symptoms for three years. Fundiscopic examination shows no change in 2½ years.

CASE 3. (J. W.)—This 14-year-old white male was referred to my service by Dr. C. F. Wilson who felt that the chorioretinitis was typical of toxoplasmosis in a chronic stage. The entire examination was negative for other evidence of disease, but the blood serum sent to the National Institute of Health, Bethesda, Md., showed a dye test titre well within the range of sub acute toxoplamosis. This patient was not placed on treatment, other than that prescribed by Dr. Wilson for vision error, due to the lack of evidence of present activity. He is being closely followed because of danger of reactivation.

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Summary

The epidemiology, pathology, clinical characteristics and treatment of toxoplasmosis are reviewed.

The importance of including toxoplasmosis in the differential diagnosis of certain cases is stressed. The opthalmologist, obstetrician, pediatrician and internist probably have the best chance of discovering toxoplasmosis.

The signs of toxoplasmosis are: (1) congenital or neonatal meningoencephalitis, usually associated with hydrocephaly, chorioretinitis, cerebral calcifications and convulsions; (2) atypical encephalitis; (3) postencephalitic sequelae; and (4) pneumonitis associated with fever and rash.

Three cases found in the Pikeville area are presented, along with x-rays showing typical cerebral calcifications in one case.

Malignant Thyroid Adenoma

To ascertain if the grade of differentiation was a determinative factor in the clinical course of malignant thyroid adenomas, a 15-year survey of over 3,000 thyroidectomies was undertaken. Two hundred sixty-six cases of thyroid cancer were divided into two groups on the basis of the survival rate and the natural history of the tumor. One hundred fifty-six adenomas satisfied the dual criteria of being both solitary and a group 1 type of malignancy (well differentiated with favorable prognosis). Treatment consisted of either a total lobectomy or a combination of total and subtotal lobectmy with few modified neck dissections and no resort to X-ray or radioactive iodine as adjuvant therapy. With a 12-year followup of 88% of the patients, the survival rate exceeded 90% and the apparent cure was 85%.

—*J. W. Welch, V. E. Chesky and C. A. Hellwig, AAA Archives of Surgery, July,* 1960

Estrogen Therapy For Active Gastro-Intestinal Bleeding

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The effect of intravenous Premarin administration in 16 active cases, half of which responded to 24-hour treatment, is reported. Pertinent literature is reviewed

DURING the past few years, reports have appeared in the literature with respect to the therapeutic value of the intravenous administration of estrogen for control of spontaneous hemorrhage, such as epistaxis, excessive postoperative bleeding from tonsillectomies and, on occasion, from urological procedures.[6, 9]

Dramatic response to estrogen in the case of functional uterine bleeding is strongly supported by demonstrating the estrogen level in the blood stream. Uterine bleeding has been rapidly arrested by giving 20 mg. of Premarin® intravenously, followed by 20 mg. intramuscularly every 4 to 6 hours for two to four doses, followed by oral therapy.[24, 5] It should be remembered that nearly complete shedding of the endometrium occurs with normal menstruation. This is a chemical curettage brought about by sudden withdrawal of the hormonal (estrogren and progesterone) support of the endometrium.[24]

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®*Equine conjugated estrogens, supplied by Ayerst Laboratories, New York, N. Y.*

The author wishes to thank Dr. J. W. Scott, Dr. T. Scott, Dr. W. Best, Mr. W. S. Murphy and the Medical Staff of Good Samaritan Hospital, Lexington, Ky.

Method and Material

This study was conducted in the Good Samaritan Hospital, Lexington, Kentucky, in Medical and Surgical Services over an eight-month period. Nearly all patients, reported individually here, had active, and some had massive gastro-intestinal hemorrhage, especially during the administration of estrogen.

Evaluation of the activity of bleeding was frequently difficult. The conclusion in each case was based on clinical and laboratory methods. Almost all cases had prothrombin time, bleeding time and coagulation time determined before administration of estrogen, and again after 24 hours. All cases were kept on a 24-hour Premarin schedule. The first, "attack doses", were large: 20 mg. intravenously at once, repeated in 20 minutes and an hour later, then four doses more, given every six hours. The assumption was that the first doses would arrest bleeding, while subsequent doses would maintain hemostasis.

The 16 cases were divided as follows: nine cases bleeding from peptic ulcer, three cases from esophageal varices, two cases from undetermined sources, one case from cancer of the stomach, and one case from acute liver failure.

Analysis of the Cases

Briefly, in eight cases bleeding appeared to have ceased following estrogen administration; but it is almost impossible to reach definite conclusions as to whether bleeding was stopped by the estrogen or by itself. The remaining six cases showed no benefit at all. Four out of nine peptic ulcer cases had to undergo emergency surgery, and active arterial bleeding was found. The remaining five cases got well. In all cases the usual pertinent therapy was never

neglected. Two cases of bleeding from esophageal varices improved. Another case bled profusely during the six-hour schedule. The acute liver failure case and the cancer of the stomach had no benefit from estrogen therapy.

TABLE I

Case No.	Bleeding from	Result after estrogen
1.	Diverticula in colon?	Bleeding Stopped
2.	Esophageal veins	Bleeding Stopped
3.	Marginal ulcer	Bleeding Stopped
4.	Duodenal ulcer Chronic G.I. bleeder	Bleeding Stopped
5.	Profusely bleeding marginal ulcer,	Bleeding Continued
6.	Acute liver failure	Bleeding Continued
7.	Duodenal ulcer	Bleeding Stopped
8.	Arterial duodenal ulcer bleeding,	Bleeding Continued
9.	Cancer of Stomach	Questionable
10.	Prepyloric ulcer	Bleeding Stopped
11.	Esophageal varices	Questionable
12.	Duodenal ulcer	Bleeding Stopped
13.	Arterial bleeding from prepyloric ulcer,	Bleeding Continued
14.	Esophageal varices	Bleeding Stopped
15.	Unknown (uremia)	Bleeding Continued
16.	Peptic ulcer	Bleeding Continued

The following points are of special interest or controversial in the light of classical knowledge:

(1) About half of the 16 cases showed abnormally prolonged prothrombin time before estrogen was given. The average was 4-5 seconds difference between the patient's prothrombin time and the control time. One bleeding ulcer case had a 25-second prothrombin time without any determinable liver disease after the bleeding phase. These elevated prothrombin times returned to the normal level after estrogen therapy if bleeding stopped.

Two possibilities suggest themselves: (1) If estrogen has some effect in increasing prothrombin production directly or through an accelerator system, its administration should return a prolonged prothrombin time to normal; (2) During active bleeding, the platelet count and the prothrombin content of blood are being lowered. Banked blood transfusions also contribute to this lowering. Platelets and prothrombin return to normal shortly after bleeding stops but they stay subnormal during estrogen therapy, as shown below. Although Johnson[25] has shown increased Acglobulin and prothrombin content of plasma after estrogen administration, favoring the above first possibility, the second appears more acceptable to me.

In order to observe the effect of estrogen on prothrombin time, we have done in vitro and in vivo experiments on anticoagulated cases in which Premarin had no effect. In vitro tubes were left to incubate an hour after adding different concentrations of Premarin. Then prothrombin time was determined. As in the in vivo experiments, prothrombin time was determined an hour after the use of Premarin. No significant change was observed.

Frank[26] mentioned the decrease of the prothrombin content of the blood in patients with bleeding peptic ulcers. Chalmers and his co-workers reported significant variations of prothrombin content and platelet count in patients with massive G.I. hemorrhage with or without liver disease.[27] It seems logical to observe the correlation between the severity of the bleeding and the decrease of the prothrombin content of the blood. Prothrombin time determination may prove to be useful in the estimation of the degree of massive internal hemorrhage.

(2) Peptic ulcer may be more common in elderly people than is usually supposed. Clinical and laboratory findings in this group are apt to be misleading. One of our patients is a good example. He had histamine refractory achylia, but autopsy revealed two peptic ulcers in the duodenal cap. We did not determine the pH of his stomach juice.

(3) False positive BSP tests are encountered during the shock state, as illustrated by case eight.

Discussion and Review of Literature

Has there been anything proved concerning the effect of the estrogenic hormones on the blood-clotting mechanism? Many investigators have noted an alteration of the clotting factors coincidental with physiological changes in the levels of estrogenic hormones, as well as a rise in heparin-like antithrombinic activity, with the administration of synthetic estrogens.[17] Ovarian extracts have been used for control of the bleeding tendency in hemophilia.[2,3]

We recently had a case of proved factor VII deficiency which had undergone dental surgery. In spite of all the transfusions, his coagulation time did not come down below 28 minutes.

With the administration of 20 mg. of Premarin in plasma transfusion, his coagulation time dropped to 14 minutes and the bleeding stopped. However, the same therapy failed in successive days.

During pregnancy, near term, there is an elevation of the prothrombin level[11], the serum prothrombin conversion accelerator[1], and the fibrinogen levels [15]. During the menstrual cycle, the platelet count increases at ovulation and falls during menstruation.[13]

Johnson[25], studying the effects of estrogens in nine male and three female dogs, stated "There was a sharp rise in the plasma AC-globulin and prothrombin concentration. These changes began within the first 15 minutes and reached a peak in about 1½ hours. In about three or four hours normal concentrations were again found. Small decreases in antithrombin activity of plasma were found. Theoretically, all these changes tend to enhance the coagulability of the blood."

Spontaneous Hemorrhage

Jacobson[6] has proposed a "unified concept of spontaneous bleeding" and states "Extensive clinical experience and the favorable response to hormone therapy convince me that there may be a single disease which I have described and defined as 'Spontaneous hemorrhage'. The concept is advanced that epistaxis, coronary occlusion, subarachnoid hemorrhage, gastrointestinal bleeding and similar conditions may be one instead of many diseases." Jacobson's proposal has been based upon 300 cases of epistaxis, 34 post-tonsillectomy, 31 rectal, 16 gastrointestinal, 12 subarachnoid, six genitourinary and other bleeding cases. He claims that the striking results from estrogen administration could not all be ascribed to coincidence.

He repeatedly mentions the findings of Smith and Smith:[18,19] "The vessels in the uterus rupture because of the vascular toxin which is accompanied by reduction of estrogen. They contend that this substance is a euglobulin-like material which they discovered in the menstrual discharge." He also mentions the findings of Wartman:[21,22] "The depression of estrogen stimulates the vascularization of the tissue."

Although Jacobson mentions 16 G.I. bleeding cases treated with estrogen in his article, he favors the unification of spontaneous hemorrhage, saying ". . .furthermore, the lack of a definite pattern is demonstrated by the fact that, although there may be an abundance of blood in the alimentary tract, neither open vessels or ulcers nor any other source of bleeding can be found either at operation or autopsy." Undetermined causes of G.I. bleeding vary from 12 to 20 per cent in different reports. For example, in Cook County, Chicago[28] only 25 cases revealed no morphological cause found at autopsy in the series of 673 autopsied G.I. bleeders. It is impossible to ignore the pathology in the vessels during the massive hemorrhage from ulcers and varices.

Role of Hormones

Of the above-mentioned 673 cases, 511 were men, 162 were women. This sex difference suggests that the sex hormones may play some part in the disease. Since we do not definitely know the etiology and pathogenesis of some diseases in which there is bleeding, we may speculate on the role of hormones: The adrenal hormones affect gastric secretion. Uropepsinogen is increased in Cushing's disease and decreased in Addison's disease. Gastric secretion is decreased in myxedema and is normal or above in hyperthyroidism. An ulcer diathesis is seen in hyperparathyroidism. Hypoglycemia stimulates gastric secretion. Non-insulin producing islet cell tumor of the pancreas is associated with gastric hypersecretion which is called Zollinger-Ellison syndrome.

Coexistent Diseases

In the 673 cases in the Chicago series, the following coexistent diseases were found present and may be significant with respect to old age, and hormonal disturbances: coronary sclerosis, hypertensive heart disease, syphilitic aortitis, arteriolar nephrosclerosis, benign prostatic hypertrophy, hepatic and pancreatic lesions, goiter, adrenal cortex adenoma.

The important fact, it would appear, is to keep intact the hormonal integrity of the body. One of the rare causes of bleeding from the gastronintestinal tract is hereditary hemorrhagic telangiectasia, in which estrogenic hormone has been given occasionally by different authors.

The recent study reported by Harrison[29] is interesting: "Epistaxis being found to occur

more frequently during any period of decreased estrogen excretion. This is in marked contrast to the cutaneous arteriolar spider nevi which are thought to arise as a result of increasing estrogen. In three cases which were under estrogen treatment, biopsies of the nasal mucosa were taken before and after treatment. They showed considerable metaplasia of the normal columnar epithelium to well differentiated squamous epithelium. It is interesting to note that the curettings taken from the cervix of one case showed squamous metaplasia of the cervical glands, a change found by Siskin to occur experimentally when ovarectomized monkeys receive large doses of estrogens. From these histological findings it seems justifiable to conclude that the nasal telangiectasis is protected from incidental trauma by the overlying layer of squamous epithelium laid down as a result of the estrogen therapy that takes place in 3-4 weeks."

Three Possible Mechanisms

In the arresting of bleeding by estrogen administration, three possible mechanisms were suggested by Menger[9] who had had 15 epistaxis and post-adenoidectomy cases:

1. Estrogen is necessary for vascular integrity.

2. Effect on clotting mechanism. Working through an enzyme system it may either speed up the clotting or provide some missing factor. Parenterally given estrogen has been shown to lower the abnormal bleeding times in newborn infants.

3. Estrogen may stimulate the release of thrombocytes into the blood stream. (In one case, before estrogen therapy, the platelet count was 180,000. After one day, following estrogen, it was 340,000.)

Two interesting observations were made by Jacobson [6a] in his large series:

1. "Estrogen therapy can be effective only if blood escapes slowly." That has been our observation. In slow, oozing bleeding, estrogens appeared beneficial. In brisk arterial bleeding or ruptured varices, no benefit was obtained.

2. "Epistaxis associated with rheumatic fever has not responded to estrogen." Lack of response could have resulted from vascular damage which had already occurred, as in the damaged vessels in the bleeding ulcer cases.

Both observations surely rather favor the belief that coincidental events combine to arrest bleeding.

There is as yet no accurate method available for measuring the estrogen level in the blood stream. Therefore, every study depending upon that factor may turn out to be indecisive. According to Vedhius[23], who is also seeking a means of accurately determining estrogen levels, estrogen is not one compound.

Summary and Conclusion

The effect of intravenous Premarin (conjugated estrogens, equine) administration in 16 active G.I. bleeding cases has been reported.

In eight cases bleeding stopped following the 24-hour Premarin schedule. They were quite active but slow bleeding cases. Premarin had no effect on profuse arterial bleeding.

In some cases a prolonged prothrombin time returned to normal after the 24-hour Premarin schedule. However, it could not be demonstrated experimentally that Premarin has an effect on prothrombin time. In four cases which were on anticoagulant therapy, bleeding, coagulation and prothrombin times were not changed.

Pertinent literature has been reviewed.

There is no evidence to support acceptance of "spontaneous hemorrhage" as a unified concept. Since estrogen appears effective in many epistaxis cases as well as in functional uterine bleeding, its administration might affect the normal functioning of the "erectile organs" in which estrogen decreases the congestion.

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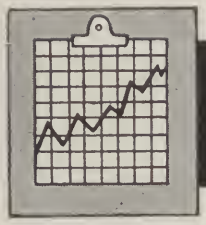
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CASE DISCUSSIONS
From The
University of Louisville Hospitals



Veterans Hospital

Carbon Tetrachloride Poisoning*

A 41-YEAR-OLD white male (#A-2884) was admitted to the Veterans Hospital at 8:00 p.m., 9/14/59 complaining of vomiting and jaundice. He had been well until the morning of 9/11, when he noted abdominal distention and nausea. He vomited 12-15 times during the first day of his illness, and again on the second day (9/12) but this gradually subsided without hematemesis.

On 9/12, the patient suffered severe, intermittent, knife-like pains in the right upper abdomen and jaundice was first noted on 9/13. He voided only a few ounces of dark brown urine during the first four days prior to hospitalization.

He denied previous digestive complaints, food intolerance or jaundice but admitted the frequent use of ethanol for many years. Detailed queries regarding exposure to carbon tetrachloride by ingestion or inhalation were met by repeated denial. He took no drugs and denied hypodermic injections, etc., for several years. There was no evidence of exposure to leptospiral infection or an individual with hepatitis.

System Review

System review and past history revealed no pertinent data.

T—99.4°, P—84, B.P.—145/85. The patient was alert, oriented and moderately ill. He answered questions briefly and could provide few details. There was icterus of sclerae and skin, moderate general abdominal tenderness and the liver was easily palpable but the spleen was not felt.

The initial data were: Hgb. 13.2 gms./100 ml.; hematocrit 42%. The urine contained bile; sp. gravity —1.009 with 4+ proteinuria and many RBC and WBC. Studies 36 hours later revealed: Total serum bilirubin—8.8 mg./100 ml. and blood urea nitrogen—52 mg./100 ml.; SGOT—810 units. Serum sodium—122, potassium—3.8; chloride—69 and carbon dioxide content—29 meq./1. The initial chest x-ray (9/15) showed slight cardiac enlargement (C:T ratio—16/29) and pulmonary congestion.

The provisional diagnosis was hepatitis of unknown cause, and intravenous glucose therapy (2000 ml. 10% D/W) was started. On the following day (9/15) improvement was apparent, vomiting had ceased and treatment was continued. Initially the oliguria was attributed to vomiting and dehydration but severe renal involvement soon became apparent. On 9/17/59, the urine volume was only 60 ml., despite a total fluid intake of 2940 ml., and the dilute urine (sp. g.—1.007) indicated severe nephron damage and no dehydration. The oliguria, isosthenuria and jaundice strongly suggested carbon tetrachloride poisoning despite repeated denial of exposure.

Exposure Verified

However, on the sixth hospital day (9/19) he unexpectedly recalled that on 9/9 he had used carbon tetrachloride to clean a ventilating hood. He had drunk several bottles of beer while working but denied drinking carbon tetrachloride. Two abstemious helpers were exposed but neither exhibited subsequent ill effect although dense fumes of the solvent precluded work for more than a few minutes.

Once the exposure to carbon tetrachloride had been verified, the fluid intake was drastically reduced. Beginning on 9/19 the daily fluid was provided by only 500 ml. of 20% aqueous glucose solution. This regimen was continued until 9/29, by which time diuresis was well established. Table I represents the major biochemical changes during the period of oliguria and recovery and Table II shows the changes in weight and fluid balance. Weight changed little until fluid intake was reduced. Thereafter, despite oliguria, steady loss occurred which was accentuated after the onset of diuresis on 9/27.

As shown in Table I, the patient excreted very small volumes of dilute, protein-rich urine and initially there was a progressive rise in blood urea nitrogen with moderate acidosis and phosphorus retention without hypocalcemia. The low serum sodium and chloride concentrations persisted during oliguria with a decline in hematocrit. There was no chemical or electrocardiographic evidence of hyperkalemia; the maximum concentration was 5.4 meq./1 on 9/25.

On admission the patient was jaundiced with evi-

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TABLE I

Changes During Oliguria and Recovery

MONTH	SEPTEMBER															OCTOBER				
Day	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	5	13	20	28
H'crit	42	40											32				38		31	34
Urine sp. g.	1.009	1.007			1.007			1.009			1.013								1.012	1.012
Protein	4+	4+			3+			4+			2+								0	0
Serum sodium	122	132	128	131		129	135	133	130	132	131		137		134	137	134	146	138	
Potassium	3.8	3.7	4.7	4.4		4.9	4.9	5.2	4.9	5.4	5.2		5.0		4.2	4.6	3.9	4.6	4.6	
Chloride	69	76	80	82		82	85	85	78	75	77		84		89	87	93	104	104	
CO_2	29	25	28	21		21	19	19	19	18.7			19		20	21	21	23	25	
Calcium						4.7		4.9					4.8				4.9			
Phosphorus						3.8		4.5					6.0				2.0			
Total Bilirubin	8.8	9.6	11.6	9.2		6.2							3.7		3.1		2.1		1.0	1.0
S.G.O.T.	810			42									5.0							
B.U.N.	52	105	113			133	137	116		147	147		165	167	162	156	132	32	20	21
Urine Vol.	30	60	0	30	0	45	350	322	280	335	820	880	1090	1370	1990	3360	3230			

Serum electrolytes expressed in meq./liter
Phosphorus, bilirubin and urea nitrogen in mg./100 ml.

dence of severe liver injury. The SGOT was 810 units, cephalin flocculation—4+ and thymol turbidity—3.7 units on 9/16. The maximum total serum bilirubin was 11.6 mg./100 ml. on 9/18; thereafter a slow decrease occurred but a normal value was not found until 10/20.

As oliguria continued, the patient began to complain of dyspnea, orthopnea and cough. On 9/17, moist rales were heard at the lung bases and a persistent elevation of blood pressure noted, (maximum —200/120). On 9/24, an x-ray showed no cardiac change but pulmonary congestion had increased. By 9/26 respiratory difficulty became severe with marked pulmonary edema. Prompt digitalization was followed by striking improvement and the drug was discontinued two days later. However, much of the remarkable recovery must be ascribed to the onset of diuresis and not to digitalis alone.

The mode of onset of the diuretic phase was noteworthy, (Table I). Although the rise in BUN during the period in which the urine volume was approximately 300 ml. per day was not surprising, its continued rise after the urine volume approached 1000 ml./day (9/26) was unexpected. The maximum value of 167 mg./100 ml. was found on 9/29. A significant fall did not occur until 10/1 when the daily urine volume exceeded 3000 ml. Perhaps a more abrupt decline in BUN would have been observed had the fluid intake been increased during the period 9/26-9/29. However, the hypertension, pulmonary congestion and heart failure, already noted, justified the rigid restrictions which were continued through 9/29. Thereafter, intravenous glucose therapy was stopped and oral fluid intake was encouraged.

By 10/1 remarkable clinical improvement had occurred and all intake restrictions were removed. A normal BUN was documented on 10/20 and on 10/28/59, the patient was discharged with essentially normal biochemical values but isosthenuria and moderate anemia still persisted.

Discussion

In view of the recognized toxicity of carbon tetrachloride, its former medical uses and success as an anthelmintic are quite remarkable. However, sporadic examples of iatrogenic hepatic injury and experimental data have provided sufficient evidence to interdict the use of this drug.

Nevertheless, carbon tetrachloride is widely used because of its unexcelled qualities as a solvent for grease, fat, waxes, paints, etc. It is often used in fire extinguishers and, lacking the hazard of flammability, is a frequent component of "safe" household cleaning fluids which are in daily use by many who are unaware of its toxicity, and sporadic examples of serious poisoning are relatively common.

The clinical picture following exposure to carbon tetrachloride depends upon the intensity of the exposure, its route of entry and individual susceptibility. Consequently, the severity of the illness may vary widely even among individuals of a group who receives essentially the same exposure.

The manifestations of carbon tetrachloride poison-

TABLE II

Summary of Weight and Fluid Balance

MONTH	SEPTEMBER																OCTOBER		
Day	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	5
Oral Intake	?	1000	2240	1280	100	0	0	70	240	100	50	150	100	50	310	1280	1750	1560	1920
Vomitus	?	300	0	0	0	0	0	0	0	100+	0	0	0	0	0	0	0	0	0
I-V Fluids	2000	1000	700	200	324	500	500	500	500	500	500	500	500	500	500	0	0	0	0
Urine Vol.	60	?	30	60	0	30	0	45	350	322	280	335	820	880	1090	1370	1990	3360	2980	3230
Weight	151	150	150	149	149	148	146	147	146	145	144	141	139	137	134	132	132	126	121

Volumes are in ml.; weight in pounds.

ing have been divided into four categories. Anesthetic, nonspecific, hepatic and renal. Considerable variation is frequent and an individual may show more than one type of injury.

I. ANESTHETIC TYPE: The inhalation of concentrated fumes of carbon tetrachloride may produce sudden collapse and death which is presumed to be due to depression of vital medullary centers or cardiac arrhythmia.[1, 4, 9] Survival of the immediate exposure unfortunately entails the risk of subsequent hepatic and/or renal damage.

II. NONSPECIFIC TYPE: Although there is evidence that the chronic inhalation or ingestion of small amounts of carbon tetrachloride may be injurious, the exact identity of this so-called "symptomatic" poisoning is not well established since there has been little or no proof of renal or hepatic disease.

III. HEPATIC TYPE: The hepatic or fulminant type of injury is the classical form of severe carbon tetrachloride poisoning. Jennings[4] reports four victims (three by ingestion; one by inhalation) who survived 51-96 hours. Autopsy revealed massive hepatic necrosis, despite the fact that only one patient was jaundiced. There was severe centrilobular necrosis which often involved the mid-portion of the hepatic lobule. Moon[7] reports similar findings in two patients. Maximum liver damage apparently occurs within 48 hours.[11] Patients who die within one week invariably show severe hepatic damage[10] and renal involvement contributes relatively little to the early fatal outcome.

Severe Poisoning Uncommon

Fortunately, such severe poisoning is uncommon and tends to occur only after intense exposure, usually by ingestion, or in individuals such as the alcoholic, whose liver is unusually susceptible.[21] Some liver injury is almost always present in patients requiring hospitalization but those who survive more than five days do not have massive necrosis and hepatic involvement is not the decisive factor in survival.

There is ample evidence to establish the susceptibility of the alcoholic to carbon tetrachloride injury.[2, 4, 5, 6, 7] Although the exact cause is poorly understood, it is clear that there is a much higher incidence of poisoning involving the liver as well as the kidney among alcoholics than in the non-alcoholic individual who receives the same exposure. The former is vulnerable in two ways: (1) During periods of heavy ethanol intake he may drink carbon tetrachloride by accident. (2) The lipid-laden liver of the chronic alcoholic is apparently quite sensitive to injury by carbon tetrachloride.

The severity of the latter appears to depend upon the affinity of carbon tetrachloride for the lipid within the hepatic cell.[6] The simultaneous ingestion of ethanol and carbon tetrachloride apparently increases the toxicity of the later.[8, 2]

IV. RENAL TYPE: It is now apparent that carbon tetrachloride is a potent nephrotoxin whether exposure is by inhalation or ingestion. The physician is much more apt to see a patient with severe renal than other types of carbon tetrachloride poisoning.[8] According to Joron,[5] it is much commoner than massive hepatic necrosis. Jennings[4] in reviewing 75 fatal cases from the files of the Armed Forces Institute of Pathology noted 71 examples of severe renal involvement.

The characteristic clinical syndrome produced by carbon tetrachloride is acute renal failure (acute tubular necrosis, lower nephron nephrosis, shock kidney, etc.). This may be defined as "the clinical syndrome resulting when renal excretory function is rapidly but temporarily lost because of alterations in renal circulation and the development of disseminated areas of renal tubular degeneration."[13] It is now clear that there are a multitude of causes of this type of renal injury but that carbon tetrachloride occupies an important position among toxic agents. Regardless of the exact cause, however, the clinical manifestations of acute suppression of renal function are remarkably similar.

Pathological Lesions

Oliver, et al[14] have described the pathological lesions in detail. Two distinct lesions were found: The nephrotoxic agent produces diffuse degeneration of large segments of the proximal tubular epithelium without disruption of the basement membrane. The second lesion is ascribed to ischemia and consists of scattered areas of focal necrosis which may involve any portion of the nephron. This lesion is associated with disruption of the tubular architecture as well as the basement membrane. The latter lesion is characteristic of the changes seen in the kidney as a consequence of shock but both lesions are observed when exposure to a nephrotoxic agent such as carbon tetrachloride has occurred.

Sirata[15] emphasizes the importance of interstitial renal edema consequent to the action of the nephrotoxic agent. The selective osmotic activity of the proximal tubule is lost with leakage of the glomerular filtrate back into the adjacent interstitial tissue. With the increasing renal edema, there is further decline in glomerular blood flow. These factors acting in combination apparently account for the oliguric phase of acute renal suppression. It would appear that continuing renal ischemia is largely responsible for persistence of the oliguria but there is considerable doubt that edema alone can account for the marked reduction in renal blood flow.

Three Phases

Renal failure of the type under discussion may be divided into three separate phases or periods as follows: (1) the oliguric phase, (2) the diuretic phase, (3) the recovery phase.

Of these, the oliguric phase has received most attention because it constitutes the outstanding early clinical feature of the disorder. Oliguria may be said to exist if the daily urine volume is below 400 ml. although the urine volume is often as low as 30-60 ml./day. It is important to note, however, that complete anuria is quite unusual and provides evidence that some other disorder is present.[13] Since acute

renal suppression is usually encountered under complex circumstances associated with trauma, nausea, vomiting, etc., it is quite easy to ascribe the reduced urine volume to dehydration. Consequently, large amounts of parenteral fluids are often given in the early phase of treatment and this may significantly reduce the likelihood of ultimate survival.

In reaching a decision regarding the cause of oliguria, the specific gravity of the urine is of great value. If the patient's oliguria is due to dehydration alone and kidney function was previously normal, the urine specific gravity should remain high. On the other hand, there is rapid loss of concentrating ability of the kidney in acute renal suppression.

It is generally agreed that oliguria commences from one to three days after exposure to carbon tetrachloride, although an interval as long as eight days has been reported.[3, 5, 10, 17] The average duration of oliguria is 10 to 12 days.[13] As already noted, the urine volume may be quite low but as the end of the oliguric phase approaches, the urine volume rises slowly and then quite rapidly as diuresis begins.

Early in the oliguric phase, shortly after renal injury, the urine contains protein, erythrocytes and casts. These abnormalities tend to diminish with the passage of time but the specific gravity remains relatively constant at 1.010-1.012 until recovery is complete long after the initial insult.

Chemical Changes Complex

The chemical changes during the oliguric phase are quite complex and are often aggravated by overzealous fluid therapy. In general, these depend upon the almost total inability of the kidney to excrete water, the loss of renal homeostatic mechanisms and the retention of substances ordinarily excreted freely by the kidney. Azotemia, progressive acidosis and ultimate hyperkaliemia are to be expected. Hyponatremia and hypochloremia are common but these, as well as the anemia, are so often intensified by previous therapy that a clear explanation of the observed changes may not be apparent. Unless strict limitation of fluid intake is enforced, there will inevitably be a significant expansion in the body water. It is quite likely that there is a significant migration of sodium into the cells and that the total sodium deficit is much less than would be calculated on the basis of the serum concentration.

With the expanded extracellular fluid, rising BUN and increasing acidosis, the victims of acute renal suppression are exceedingly susceptible to acute pulmonary edema. This is by far the leading cause of death under these circumstances and all treatment should be designed to prevent it. As illustrated in the present case, if the patient can be protected from this eventuality, the likelihood of recovery of renal function improves greatly. Hypertension is a common feature of this disorder and it may contribute to the heart failure which in turn contributes to the development of pulmonary edema. However, it is unlikely that heart failure alone suffices to explain the readiness with which these patients develop acute pulmonary edema.

Hyperkalemia is often regarded as the second leading cause of death in acute renal failure.[20] Swan, et al,[13] report potassium intoxication (a serum concentration in excess of 8 meq./1.) in one-fourth of their cases. It appears probable that the hyponatremia accentuates the clinical manifestations of hyperkalemia. The electrocardiogram is a valuable adjunct in providing evidence for abnormally high potassium concentrations and is quite valuable when corroborated by chemical analyses; the latter are usually necessary when hemodialysis is contemplated.

Among individual patients, the minor manifestations of acute renal shut-down with sustained oliguria may exhibit wide variations. In an occasional patient they may constitute an outstanding feature of the clinical problem. These include: Nausea, vomiting, abdominal distension and discomfort.[16] Diarrhea may occur but it is relatively uncommon. Patients often show aberations of cerebral function and may become progressively more lethargic and obtunded as azotemia increases.

Beginning Recovery

If the patient survives the oliguric phase and its grave risk of death in pulmonary edema, the beginning recovery of renal function is ushered in by a gradual or abrupt rise in urine volume. Once this volume exceeds 1000 ml. daily, the ultimate onset of effectual diuresis and recovery may be anticipated with confidence. "It probably represents the reestablishment of the tubular barrier to indiscriminate back diffusion of the filtrate."[15] Although the kidney rapidly resumes the ability to excrete large volumes of dilute urine and thereby solves the most pressing clinical problem of hypertension, congestive heart failure and pulmonary edema, its ability to perform osmotic work remains severely limited. Consequently, the chemical abnormalities, especially the azotemia, may persist for two to four days after a significant diuresis is established.

During diuresis, the loss of fluid is often remarkable and the patient may lose 5-25% of his body weight. The greatest losses will occur in those individuals with severe edema; if fluid restriction has been rigid, weight loss during diuresis may not be striking. The inability of the kidney to conserve salt and water during active diuresis may lead to marked dehydration and NaCl deficit which mimic Addison's Disease. Here it is essential that an adequate intake of salt and water be provided.

After the end of the diuretic phase, the kidney slowly regains a state of function which approaches normal, i.e., when the urine volume becomes a function of the fluid intake. Renal blood flow and glomerular filtration rate increase by about the 40th day and approach the lower limit of normal after about 100 days. The kidney only regains its ability to elaborate a concentrated urine late in the recovery phase.[15] Although recovery is quite slow, its completeness is truly remarkable in relation to the severity of the initial renal involvement.

Treatment

"The therapy of carbon tetrachloride nephrosis should be directed toward the prevention and control of congestive heart failure with little regard for the

concommitant azotemia and almost always without regard to the associated acidosis and electrolyte disturbance."[18] Spontaneous diuresis with complete recovery is the rule if pulmonary edema is avoided. The outcome is determined neither by the duration of oliguria nor the height of azotemia.[9, 17]

Actually, the immediate fate of the patient rests squarely on the skill of his physician in supplying only that amount of fluid which the patient loses each day. In the face of virtually complete lack of urine excretion, even small excesses of fluid may precipitate acute pulmonary edema and death. The gain of small increments of water on successive days will lead inevitably to pulmonary edema as demonstrated in the case reported here.

Despite very close attention to fluid balance, the error is almost always in the direction of overhydration, not underhydration. Neglect of the water derived from the catabolism of foodstuffs may determine the patient's survival during the oliguric phase. It is probably safe to say that sodium salts should never be given, although excessive losses via the gastrointestinal tract may necessitate careful replacement of sodium and chloride. It is obvious that potassium should never be given as long as oliguria persists.

Strauss[19] has made some practical suggestions. In treating an individual weighing 70 kg., he assumes an insensible water loss of 1 liter per day. Approximately 470 ml. will be derived from the oxidation of glucose, protein and fat and the patient will, therefore, require 530 ml. of salt-free water to meet his needs. Furthermore, it is desirable to curtail the catabolism of protein to reduce the rate of rise of the serum potassium as well as the BUN. The maximum protein sparing effect can be achieved with about 100 gms. of glucose daily which also prevents the ketoacidosis of starvation.

These suggestions were followed in the treatment of the patient reported here. One hundred grams of glucose were given daily as 500 ml. of 20% aqueous solution. Despite these restrictions, pulmonary edema became a difficult problem late in the period of oliguria. This is attributed to the initial period of overhydration and to the fact that the insensible water loss may have been less than was surmised.

The experience reported here emphasizes the value of weighing the patient carefully each day. This has also been recommended by others, notably de Wardener.[12] Therapy should be designed so that the patient loses 1-1.5 lbs. daily.

Although hyperkalemia was not encountered in this patient, it may be fatal in patients with protracted oliguria. Various temporary measures have been proposed but hemodialysis with an artificial kidney constitutes the best form of treatment.[6, 20] However, as illustrated in this case, careful restriction of fluid intake to minimize the hazard of pulmonary edema will often permit the recovery of renal function without the need for hemodialysis. These measures are particularly important when an artificial kidney is not available.

Summary

*Beverly T. Towery**—This report deals with the commonest type of serious carbon tetrachloride poisoning and re-emphasizes the vulnerability of those who indulge in alcoholic beverages. It clearly presents the problems encountered in the management of acute renal failure and is especially valuable because of the intensive studies which were carried out. These observations provide an excellent guide in the treatment of such patients regardless of the cause of the renal lesion.

The recovery of this patient after approximately 15 days of oliguria is a credit to those who cared for him. The difficulty in avoiding overhydration is apparent but this is the crucial goal in the management of acute tubular necrosis.

Follow-up studies on 8/4/60 were: Hematocrit—48%; a urine concentration of 1.026 was observed during fluid restriction; the BUN was 16 mg./100 ml.; there was no laboratory evidence of hepatic abnormality. Full recovery from carbon tetrachloride injury had occurred. Nevertheless, the slight hepatomegaly and continued indulgence in alcohol suggest that ethanol, not carbon tetrachloride, will determine the eventual outcome.

**Chairman, Department of Medicine, University of Louisville School of Medicine.*

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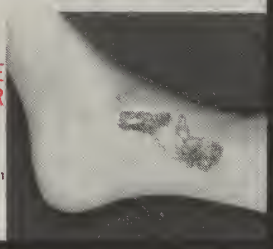
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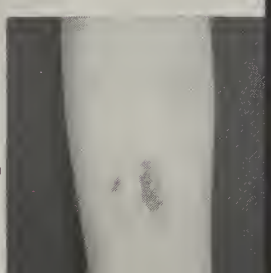
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SPECIAL ARTICLES

How the National Institutes of Health Carry On The Extensive PHS Grant and Award Programs

13 categorical Institutes have charge of appropriations and programming, 10 Advisory Councils review applications and make recommendations, and 34 Study Sections act as technical advisers

Ernest M. Allen, Sc. D.*

THE Public Health Service is charged with the responsibility for conducting and supporting research into the causes, diagnosis, prevention and treatment of diseases and disabilities of man. In addition to the extensive research conducted in Government laboratories, the Service provides support of research and training in non-Government institutions.

The Division of Research Grants of the National Institutes of Health has administrative responsibility for the management and policy direction of the Public Health Service research grants program. The appropriations and programming responsibilities fall in the following 13 categorical Institutes and Divisions of the Public Health Service:

National Cancer Institute, National Heart Institute, National Institute of Allergy and Infectious Diseases, National Institute of Arthritis and Metabolic Diseases, National Institute of Dental Research, National Institute of Mental Health, National Institute of Neurological Diseases and Blindness, Division of Engineering Services, Division of General Health Services, Division of General Medical Sciences, Division of Hospital and Medical Facilities, Division of Nursing Resources, and Division of Special Health Services.

Although a very small research grant program was supported by the National Cancer Institute following the passage of the National Cancer Act in 1937, it wasn't until the close of World War II in 1945 that the present across-the-board research grant program was born. Agreement was then reached that responsibility for approximately 50 research projects should be transferred to the Public Health Service from the Office of Scientific Research and Development, and that the Division of Research Grants should be established to administer the program.

Associate Director, National Institutes of Health, Public Health Service, Department of Health, Education and Welfare.

During the period 1946 to 1950, the Congress authorized the above-mentioned categorical Institutes, following the general pattern of the National Cancer Institute. In each instance, provision was made for research to be conducted within the facilties of the Institute, for research grants and fellowships to nonfederal scientists, and for other types of academic and research training.

By Congressional authority, 10 National Advisory Councils have been established as advisers to the Public Health Service. No research or training grant may be paid by the Surgeon General unless recommended for approval by one of these Councils. Seven of the Councils advise the seven Institutes of the National Institutes of Health on their respective programs.

Advise Surgeon General

The National Advisory Health Council reviews applications for general or noncategorical research and training grants not falling within the interest of the Institutes, and advises the Surgeon General on matters relating to health activities and functions of the Service. The Federal Hospital Council advises the Surgeon General on matters relating to the administration of the Hospital Survey and Constructions Program and reviews applications for grants in aid of projects in research, experiments or demonstrations relating to the development, utilization and coordination of hospital services, facilities and resources.

The National Advisory Council on Health Research Facilities, established in July 1956, reviews and recommends appropriate action on applications submitted by universities or other nonprofit institutions for assistance in the construction and/or equipping of additional facilities for the conduct of research in the sciences relating to health.

In view of the large number of applications which must be evaluated, covering the entire range of medical and biological research, the Division of Research has established 34 Study Sections of special consultants expert in various fields of research. These study sections act as technical advisers to the National Advisory Councils and to the Surgeon General. They accept responsibility not only for providing technical advice on applications for research support but also in conjunction wth the Councils, for surveying as scien-

tific leaders the status of research and training in their particular fields in order to determine areas in which additional activity should be initiated or expanded.

Brief functional statements for the principal types of grants and awards made by the Public Health Service in support of research, training and construction are shown as follows:

1. RESEARCH GRANTS—Research grants are made to universities, hospitals, laboratories and other public or private institutions and to individuals for support of research projects in health, medicine and allied fields, including experiments or demonstrations relating to the development, utilization and coordination of hospital services, facilities and resources. The major objectives of the research grant program are:

(a) to expand medical and biological activities in research institutions throughout the country;

(b) to provide on-the-job training for scientific personnel in connection with the research being conducted, and

(c) to stimulate new investigations in fields needing exploration. These funds provide for salaries, equipment, supplies, travel, and other expenses such as renovation and alteration of existing facilities, reprints, hospitalization.

2. RESEARCH FELLOWSHIPS—Seven types of research fellowships are available:

(a) *Predoctoral Research Fellowship,* awarded to qualified persons who hold a Bachelor's degree or equivalent training. Fellows are expected to carry on studies oriented toward graduate training in fields related to the health sciences;

(b) *Postdoctoral Research Fellowship,* awarded to qualified persons holding a Doctor's degree in medicine, dentistry or related fields. Stipends and extra allowances are awarded under established Public Health Service policy;

(c) *Special Research Fellowship,* awarded to qualified applicants who have demonstrated unusual competence for research, or who require specialized training for a specific problem. The amount of the stipend is set in each case;

(d) *Student Part-time Research Fellowship,* designed to give students in medicine, dentistry, nursing and public health an opportunity to explore the research field in the hope that many of those supported will enter into full or part-time research careers. A predetermined number of these Fellowships may be awarded each year;

(e) *Senior Research Fellowship,* granted in support or preclinical science investigators between the completion of postdoctoral training and eligibility for permanent academic appointment. These funds provide for salaries plus research expenses not exceeding $2,000. The Senior Research Fellows may also apply for research grants to support their research;

(f) *Post-Sophomore Research Fellowship,* designed to support students who wish to obtain research training prior to completion of their professional degrees;

(g) *Foreign Research Fellowship,* awarded to a limited number of scientists who wish to study in U. S. laboratories. The purpose of the program is to provide an opportunity to strengthen medical research by mutual exchange of research methods, scientific philosophy and cultural values. Funds provide for stipends, travel and certain other extra allowances.

3. UNDERGRADUATE TRAINING GRANTS—Undergraduate training grants are awarded to medical schools, dental schools, public health schools, schools of nursing, and schools of osteopathy to assist in developing expanded and better integrated undergraduate instruction in the special fields concerned. It is the responsibility of the institution to determine the most approprate use of the funds.

4. GRADUATE TRAINING GRANTS—Graduate training grants are awarded to public and private nonprofit institutions interested in providing special training for researchers, teachers and prospective practitioners interested in public service. These funds may be used to improve facilities and to provide salaries for faculty, staff and trainees, along with the necessary supplies and materials.

5. TRAINEESHIPS—A series of traineeship stipends are awarded either directly to the individual in training or through a training grant to the institution for this purpose. Traineeships are awarded to physicians and other professional personnel in order to encourage specialization in one of the branches of medicine supported. Stipends and extra allowances are made under established PHS policy.

6. HEALTH RESEARCH FACILITIES—Under the Health Research Facilities Act, July 1956, the Congress authorized the establishment of a program to assist in the construction and/or equipping of additional facilities for the conduct of research in the sciences relating to health by providing grants in aid on a matching basis to public and private nonprofit institutions. The amount of Federal funds awarded may not exceed 50 per cent of the total costs of the research portion of the facility, the remaining sum to be provided from nonfederal sources.

Public Health Service programs in support of research and training in universities, hospitals and other nonfederal institutions have justified continued Congressional interest, as evidenced in the following table which shows the growth of the programs by appropriation year:

	Research Grants	Fellowships	Training Grants*	Health Research Facilities
1946	$ 780,000	$ 44,000	$ 29,000	$ .....
1947	3,576,000	178,000	250,000	.....
1948	9,145,000	520,000	2,810,000	2,303,000
1949	10,871,000	1,115,000	3,930,000	.....
1950	13,065,000	1,448,000	6,415,000	5,775,000
1951	16,713,000	1,565,000	6,928,000	9,459,000
1952	18,173,000	1,755,000	7,392,000	4,625,000
1953	20,374,000	2,024,000	8,194,000	.....
1954	28,866,000	2,133,000	10,813,000	.....
1955	33,918,000	2,562,000	11,051,000	.....
1956	38,038,000	2,800,000	14,502,000	.....
1957	93,300,000	5,397,000	28,075,000	30,000,000
1958	101,265,000	6,812,000	32,560,000	30,000,000
1959	145,391,000	10,408,000	49,902,000	30,000,000
1960	202,948,000	14,570,000	75,037,000	30,000,000
Proposed for 1961				
(House)	240,189,000	15,070,000	78,894,000	25,000,000
(Senate)	383,500,000	22,500,000	132,000,000	50,000,000

*Includes traineeships

EDITORIALS

'No Less Precious'

RECENTLY there was mailed to physicians a pamphlet with the above title, published and distributed by the Kentucky Association for Retarded Children of which there are now twelve local units or councils in the state. The LeRoy R. Stevens School for Retarded Children at 809 East Washington Street, Louisville, has been in operation for several years and the Sheltered Workshop, at the same address, for training of older children, will be placed in operation this fall.

Funds for financing these agencies have been provided largely through grants from the WHAS Crusade for Children, from the entire profits of the Annual Child Welfare Carnival held by Highland Post Number 201 of the American Legion in June each year, and by generous contributions from civic organizations, clubs and interested individuals, as well as from membership dues and tuition fees.

The actual causes for mental retardation are poorly understood, but no family is immune, regardless of social, economic or educational background. It is estimated to be nine times more common than cerebral palsy, ten times more frequent than crippling polio. Approximately 120,000 retarded children are born in the United States every year. Yet, as a social, economic and humane problem it has received scant and scattered attention or research.

The Kentucky Training Home at Frankfort, our only State-supported institution in this field, needs to be improved and expanded. The establishment of two new such training schools, one in Western and one in Eastern Kentucky, is needed.

Distribution of the information and appeal contained in the "No Less Precious" pamphlet is appropriate and timely. As physicians we may well be more alert and helpful in this heretofore neglected endeavor. We can in our daily work promote a wider understanding and support and often provide professional and financial aid which is so much needed.

Sam A. Overstreet, M. D.

ORGANIZATION SECTION

Stage Is Set For Transatlantic Conference, Other Features Of KSMA's 1960 Annual Meeting Opening In Louisville Sept. 20

Once again the stage is set for the top event of Kentucky's medical year—the Annual Meeting of the Kentucky State Medical Association—giving members an opportunity to hear leading medical specialists of the nation, view the latest medical and surgical techniques, and participate in physician fellowship at its best.

The curtain will rise September 20 on the three-day program to be held at Columbia Auditorium in Louisville.

High point of the meeting will come at 2 p.m. Wednesday, September 21, when a KSMA four-man panel exchanges medical ideas with a British team of physicians across the ocean. The hour-long transatlantic hookup will be the first of its kind ever staged by a state medical association.

Discussing collagen diseases, the physicians will present actual case histories, with symptoms, treatments and criticism of what was done in each case.

The British end of the link will be held at the Orpington Hospital. (Orpington is a suburban area in the County of Kent, and Bromley is its primary city.)

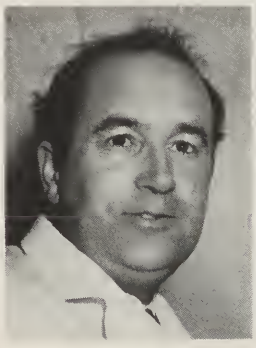
Moderating the Bromley panel will be **K. J. Randall**, M.R.C.S., L.R.C.P., consultant pathologist, Orpington and Sevenoaks Hospital Group. Other members will be **P. S. G. Campbell**, M.R.C.S., L.R.C.R., D.M.R., consultant radiologist, Bromley Group Hospitals; **C. L. Joiner**, M. D., M.R.C.P., physician, Beckenham Hospital and Guys Hospital, London (late Fellow in Medicine, Pennsylvania Hospital, Philadelphia); and **N. Southwell**, M.A., M.D., M.R.C.P., M.R.C.S., consultant physician, Orpington, Sevenoaks and Crawley Hospital, and medical specialist, Ministry of Pensions and National Insurance.

Their counterparts on this side of the Atlantic are: **Beverly T. Towery**, M.D., chairman of the Department of Medicine, University of Louisville School of Medicine, who as moderator of the host panel will open the program; **John D. Allen, Jr**, M.D., Louisville, president of the Kentucky Society of Pathologists; **David H. Neustadt**, M.D., Louisville, chairman of the medical scientific committee, Kentucky Chapter, Arthritis and Rheumatism Foundation, and **John A. Campbell**, M.D., Indianapolis, chairman of the X-ray Department at Indiana University Medical School.

Corresponding setups will be used on both sides of the ocean. On the Columbia Auditorium stage, large photo murals of the four English physicians will be hung over the heads of the KSMA panel members. Over each picture will be a light which will flash on when that doctor is speaking.

Each group will have a large screen for the simultaneous showing of duplicate slides, and the entire conversation will be heard by both audiences.

British Panel



Dr. Randall



Dr. Campbell



Dr. Joiner



Dr. Southwell

The general program of the Annual Meeting will highlight 13 top-ranking medical specialists, who will also be guest speakers at separate sessions of the state's specialty groups. John B. Reckless, M.B., a former British physician now at Duke University Medical Center, will address the President's Luncheon.

The House of Delegates will hold two sessions in connection with the Annual Meeting, the first Monday night, September 19, and the second Wednesday night, September 21. The Woman's Auxiliary of KSMA will meet simultaneously at downtown hotels.

Diabetes Detection Drive Set For Week Of Nov. 13

For the 10th consecutive year, KSMA is cooperating with the American Diabetes Association in promoting the annual Diabetes Detection and Education Drive set for the week of November 13. Franklin B. Moosnick, M.D., Lexington, chairman of the KSMA Diabetes Committee, urges every physician to contribute to the campaign by encouraging public participation and checking urine samples free for one full week.

Several diabetes chairmen failed to report the number of tests made last year by their county society memberships, according to records in the KSMA Headquarters Office. Unless such reports are received, much public-relations information of value is lost, Doctor Moosnick pointed out.

Working with Doctor Moosnick in the effort to make this year's campaign the most successful to date are: George P. Carter, M.D., Louisa; Marcus A. Coyle, M.D., Springfield; Thomas J. Crume, M.D., Owensboro; Robert J. Hoffmann, M.D., South Fort Mitchell; Arthur T. Hurst, M.D., Louisville; Esten S. Kimbel, M.D., Frankfort, and George McClain, M.D., Benton.

Program Announced For PG Course At Bowling Green Oct. 19-20

S. Benjamin Fowler, M. D., assistant clinical professor of orthopedic surgery at Vanderbilt University School of Medicine, will be the moderator for one of three panel discussions scheduled for the Postgraduate Course on Chronic Disease at Bowling Green, October 19 and 20.

The course, to be presented at the Ole Fort Restaurant, is sponsored by the KSMA Postgraduate Department, Kentucky State Department of Health, University of Louisville, University of Kentucky and American Academy of General Practice.

The program follows:

Wednesday Afternoon (2 P.M.)

Welcome—Henry S. Harris, M. D., Bowling Green, president of Warren County Medical Association

Opening—John P. Glenn, M. D., Russellville, councilor of the Sixth District

Panel Discussion, "Arthritis"—Moderator, William P. Peak, M. D., Louisville; participants, Doctor Fowler, Nashville; Rex O. McMorris, M. D., Louisville, and William Russell, Jr., M. D., Bowling Green.

Question Period.

Social Hour.

Dinner.

Wednesday Night (7:15 P.M.)

Panel Discussion, "Fractures In the Aged"—Moderator, Doctor Fowler; participants, Doctor McMorris, Doctor Peak and Doctor Russell.

Question Period.

Thursday Morning (10 A.M.)

Panel Discussion, "Cerebral Vascular Disease"—Moderator, E. D. Pellegrino, M.D., professor and chairman of the Department of Medicine, University of Kentucky Medical Center; participants, Doctor McMorris; Ephraim Roseman, M.D., professor and chief of Section of Neurology, University of Louisville School of Medicine; and Martin Wilson, M.D., Bowling Green.

Question Period.

Social Hour.

Thursday Afternoon (2 P.M.)

"The Role of the Physician In Introducing the Patient and Family to a Long Term Illness"—Doctor Pellegrino.

"Problems In Management of Patient and Family of Patient with Chronic Illness.—Wilbur A. Mitchell, M.D., Louisville.

Question Period.

Dr. Gaines Made Assistant Dean At U. L. School Of Medicine

Frank M. Gaines, Jr., M.D., associate professor of psychiatry at the University of Louisville School of Medicine, has been named to the newly-created post of assistant dean of the school. He will continue as an associate professor.



Dr. Gaines

Dean J. Murray Kinsman, M.D., said Doctor Gaines will be in charge of student affairs—a field that covers admissions, promotions, student counseling, and loans and scholarships. Doctor Gaines has been director of admissions since the fall of 1959.

A former State Commissioner of Mental Health, Doctor Gaines returned to the private practice of psychiatry in 1957. He had headed the Department of Mental Health since its creation in July 1952. He also formerly served as chairman of the Southern Regional Council on Mental Health Training and Research.

Currently Doctor Gaines is a member of the Personnel Board which will administer the new merit system for state employees.

A native of Carrollton, Doctor Gaines was graduated from the University of Louisville School of Medicine in 1941.

U. K. Center Dedication Sept. 23-24

Plans for the September 23-24 dedication of the new University of Kentucky Medical Center are complete, announces William R. Willard, M.D., vice-president of the Center and dean of its College of Medicine. The invitation list includes all members of KSMA.

Complete coverage of the opening of the College of Medicine early this month is planned for the October issue of the Journal.

Groundwork Is Laid For New Medical Care Program For Indigent Persons Starting In Kentucky January 1, 1961*

Legislative Action

The General Assembly of the Commonwealth of Kentucky in its 1960 Regular Session enacted into law House Bill No. 439 known as the Administration's Reorganization Bill, Article VII of which provides for a Medical Care Program for Indigent Persons in Kentucky. The Kentucky State Medical Association co-sponsored Article VII, along with the Kentucky Pharmaceutical Association, the Kentucky Dental Association, the Kentucky Hospital Association and the Kentucky State Association of Registered Nurses, and has been in support of such a program since it made a thorough study of the indigent situation beginning in 1952.

Although the legislation went into effect on July 1, 1960, vendor payments will not begin until January 1, 1961, allowing a six-month period for careful planning and development of the program. The scope of services and the types of medical care which will be covered have not yet been determined, but will receive early consideration by the Advisory Council for Medical Assistance.

It is generally recognized that the funds available for this program are inadequate to provide a comprehensive range of services. Therefore, it will be necessary to adjust the scope of program to funds available in such a manner as to provide the medical services which are most urgently needed. Under the program, payments for medical care rendered will be made directly to the providers of services.

Persons Eligible

The legislation provides that persons on the Public Assistance roles will be eligible for medical care. The four categories of Public Assistance recipients and the number of persons receiving aid under each category as of June, 1960, are as follows:

1) Old Age Assistance	56,116
2) Aid to Dependent Children	(17,999 Adults (54,643 Children
3) Aid to Needy Blind	2,424
4) Aid to Permanently and Totally Disabled	7,647

These 138,829 individuals, representing over four per cent of the State's population, are certified by the Department of Economic Security as meeting the requirements for such aid.

Developments to Date

Several major steps have already been made in the development of the Medical Care Program. The Governor has recently appointed the Advisory Council for Medical Assistance, which is the body designated by law to develop and formulate recommendations relating to all aspects of the program. The persons appointed to this council are:

Russell E. Teague, M.D., Commissioner, Department of Health, exofficio
Jo M. Ferguson, Commissioner, Department of Economic Security, exofficio
G. L. Simpson, M.D., Kentucky State Medical Association
E. M. Josey, Kentucky Pharmaceutical Association
Miss Nelle B. Weller, Kentucky State Association of Registered Nurses
Howard L. Bost, Kentucky Hospital Association
C. D. Carter, D.M.D., Kentucky Dental Association
Tarleton Collier, Citizen at Large
Seth Boaz, Citizen at Large
Mrs. Virginia Craft, Citizen at Large
Ed E. Ellis, Citizen at Large

KSMA Council Names Five

Five physicians have been appointed by the Council of the KSMA to serve on the Technical Advisory Committee on Physicians Services. Clyde Sparks, M.D., Ashland, will be chairman of this committee. The other four members are:

Claude C. Waldrop, M.D., Williamstown
Donald Graves, M.D., Frenchburg
Mitchell Denham, M.D., Maysville
G. David McClure, M.D., Louisville

This group will have the responsibility of informing and advising the Advisory Council for Medical Assistance on the professional aspects of the program.

A Division of Medical Care, which will be under the direction of a physician, has been created within the Department of Health and is charged with carrying out the duties and responsibilities in the program recommended by the Advisory Council.

Work At County Level

In addition, efforts have already begun by the local medical societies toward developing lists of names from which the Commissioner of Health will appoint a County Medical Review Committee for each county of the Commonwealth.

The Kentucky Dental Association has developed a similar list from which selection of the dental member of this Committee will be made.

The organizational and administrative structure of the program and the responsibilities and duties of each of the various groups involved will be described in detail in a later issue of the KSMA Journal.

Intensive planning, study, and formulation must take place between now and January 1, 1961, in order to insure the proper and effective development of the program. Cooperation, coordination and support of the various councils and committees, professional organizations and their individual members, and all other groups interested are essential if the program is to operate upon a smooth and workable basis from its inception.

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* *This is the first of a series of articles on Kentucky's new indigent medical care program which will be carried in the Journal.*

Dr. Holt Appointed Assistant Commissioner Of Health

Richard B. Holt, M.D., who was recently retired with the rank of rear admiral after 33 years in the U. S. Public Health Service, has been named Assistant Commissioner of Health by Russell E. Teague, M.D., State Commissioner of Health.



Dr. Holt

Doctor Holt will assist Doctor Teague in his general duties; will help him to develop new programs such as indigent medical care, radiological health and occupational health; and will work toward increased research efforts in county health programs. Doctor Teague stated that his experience in connection with the Hill-Burton program of hospital construction would be valuable to Kentucky.

A native of Tennessee, Doctor Holt was graduated from Vanderbilt University Medical School. He interned at the U. S. Marine Hospital, Staten Island, N. Y., and then served with American consulates in Europe.

From 1957 until his retirement in June he was chief medical officer of the U. S. Coast Guard. He entered public health service in 1927 as an assistant surgeon. From 1937 to 1941 he was medical officer in charge of the U. S. Marine Hospital in Louisville.

KSMA Host For Editors Conference In Lexington Oct. 15-16

Editors and executives of state medical journals of the Southeastern states will assemble in Lexington, October 15-16, for their Third Regional Conference, with the Journal of KSMA as host. An invitation has been extended to medical journals of all other states.

Representatives of journals in 14 states are slated to appear on the program of the two-day workshop to be held at the Phoenix Hotel. Other speakers will include Austin Smith, M.D., Washington, D. C., president of the Pharmaceutical Manufacturers Association; Albert Jackson, Chicago, president of the State Medical Journal Advertising Bureau; Edmund Pellegrino, M.D., professor and chairman of the Department of Medicine, University of Kentucky Medical Center, and Prof. J. A. McCauley, of the University of Kentucky School of Journalism.

Members of the conference will be taken on a tour of the new U. of K. Medical Center late Saturday afternoon, after which they will be dinner guests at the home of William R. Willard, M.D., vice-president of the U. of K. Medical Center, and Mrs. Willard. Later they will attend the University of Kentucky-Louisiana State University football game.

Editors of other Kentucky journals, including those of dental and pharmaceutical groups, the Kentucky Academy of General Practice and the Jefferson County Medical Society, have been invited to attend.

The KSMA Journal's editor, Sam A. Overstreet, M.D., and associate editor, George W. Pedigo, Jr., M.D., both of Louisville, are chairman and cochairmen, respectively, of the conference. Jack L. Chumley, M.D., Louisville, scientific editor, will also take part in the program.

Symposium On 'Gastroenterology' Planned For October Issue

"Selected Aspects of Gastroenterology in General Medicine" is announced as the general subject of the third annual Scientific Symposium, scheduled for the October issue of the Journal of KSMA. The two previous symposiums were on "Diabetes" and "Carcinoma of the Lung."

Special editor of this year's symposium is E. D. Pellegrino, M.D., professor and chairman of the Department of Medicine at the University of Kentucky Medical Center, Lexington.

Doctor Pellegrino has announced the following titles and authors of the 1960 papers:

I. **Differential Diagnosis With Abdominal Pain**
   a. **Medical Aspects**—David Johnston, M.D., Lexington Clinic, Lexington
   b. **Neuropsychiatric Aspects**—Richard D. Chessick, M.D., U.S. Public Health Service Hospital, Lexington

II. **Intestinal Malabsorption**
   a. **Celiac Syndromes**—Samuel Cheng, M.D., assistant professor of medicine, University of Louisville School of Medicine
   b. **Parasitism and Intestinal Malabsorption**—Doane Fisher, M.D., Chief of Pediatric Service, Harlan Memorial Hospital

III. **Gastrointestinal Bleeding**
   a. **Considerations In the Management of Upper Gastrointestinal Bleeding**—Richardson Noback, M.D., associate professor of medicine, University of Kentucky Medical Center
   b. **Proctologic Aspects of Bleeding from the Lower Bowel**—O. T. Evans, M.D., Lexington

IV. **Bile Pigment Metabolism—In the Differential Diagnosis of Jaundice**—Matthews Darnell, Ph. D., M.D., Lexington

Roentogenographic Consideration In the Differential Diagnosis of Jaundice—Harold Rosenbaum, M.D., chairman of the department of radiology, University of Kentucky Medical Center

KSMA Journal Editors Re-elected

Sam A. Overstreet, M.D., and George W. Pedigo, Jr., M.D., Louisville, were re-elected editor and associate editor, respectively, of the Journal of KSMA at an open meeting of the Council in Louisville on July 28. Both were renamed for two years.

Doctor Overstreet was first elected editor to succeed th late Guy Aud, M.D., who resigned in the summer of 1958. The practice of electing an associate editor was started at this time also.



Newest addition to Louisville's Medical Center is the $6,250,000 Methodist-Evangelical Hospital on Broadway at Floyd, which opened early this month. The curved lobby and entrance section in front contains a small chapel.

Methodist-Evangelical Hospital Opens in Louisville

Louisville's new $6,250,000 Methodist-Evangelical Hospital opened early this month, adding a potential 300 beds to the city's facilities for administering to the sick.

The six-story structure, located on Broadway at Floyd, is completely air-conditioned and is equipped with the latest push-button techniques. A completely automatic pneumatic tube system provides 24-hour service to all units of the hospital.

The radiology department includes diagnostic X-ray, radiation therapy and nuclear medicine. Within the laboratory, emphasis has been placed on automation to aid in more accurate and rapid performance of technical procedures. It will be equipped to perform many highly technical procedures in the field of protein and steroid chemistry.

Paul W. Ahlstedt, administrator of the hospital, has been on the scene since the drawing-board stage. Sam A. Overstreet, M.D., Louisville, is president of the staff; Edward Fadell, M.D., formerly of Fort Knox, is the full-time pathologist, and Orson Smith, M.D., is the full-time radiologist.

Dr. Simpson Represents KSMA As Medical Care Adviser

G. L. Simpson, M.D., Greenville, represents the Kentucky State Medical Association on the new Advisory Council for Indigent Medical Assistance appointed by Governor Bert Combs. The law specifies that the Council shall function in an advisory capacity in establishing and administering the new medical care program which becomes operative January 1. Doctor Simpson's terms is for four years.

Other appointees and their terms are:

E. M. Josey, Frankfort, representing the Kentucky Pharmaceutical Association, and Tarleton Collier, Louisville, one year.

Miss Nelle B. Weller, Louisville, representing the Kentucky State Association of Registered Nurses, and Seth Boaz, Mayfield, two years.

Howard L. Bost, Lexington, representing the Kentucky Hospital Association, and Mrs. Virginia Craft, Whitesburg, three years.

C. D. Carter, D.M.D., Bowling Green, representing the Kentucky Dental Association, and Ed. Ellis, Frankfort, four years.

The nine members will serve with Economic Security Commissioner Jo M. Ferguson and State Health Commissioner Russell E. Teague, M.D.

Madisonville TB Hospital Plans Sixth Seminar Oct. 12

Wednesday, October 12, is the date announced for the Sixth Postgraduate Seminar of District One State Tuberculosis Hospital, Madisonville.

The First, Second and Third Councilor Districts of KSMA have been asked to sponsor the symposium, along with the Kentucky Academy of General Practice and the Kentucky State Tuberculosis Hospital Commission. Two hours of Category I credit by AAGP has been requested, according to A. B. Dickey, M. D., hospital director.

The program will open at 5 p.m. with registration and guided tours of the hospital, followed by dinner and a scientific program. Essayists will be Arthur M. Schoen, M.D., associate professor of medicine, University of Louisville School of Medicine, who will talk on "Infectious Hepatitis," and Dorothy T. Magallon, M.D., Tuberculosis Control Officer, State Department of Health, who will discuss "Newer Concepts of Tuberculosis Control."

Invitation List Announced For New Member Luncheon

Personal invitations have gone out to all physicians who have joined the KSMA since September 1, 1959, to attend a luncheon at the Brown Hotel on Tuesday, September 20, according to N. L. Bosworth, M.D., Lexington, chairman of the KSMA Committee on Public Information and Service. Tickets were to be mailed early this month.

The annual luncheon, a new feature of the Annual Meeting last year, is planned to welcome new members and acquaint them with the services offered by KSMA.

The new members follow:

Anderson
Lewis E. Wash, Lawrenceburg

Bell
Francis A. Forde, Middlesboro
Philip L. Fuson, Middlesboro
Charles L. Kirkpatrick, Middlesboro

Boyd
Maurice J. Murphy, Ashland
Robert A. Stewart, Ashland

Breckinridge
William D. Hatfield, Irvington

Calloway
Thomas G. Parker, Murray

Campbell-Kenton
Thomas J. Huth, Newport
Robert W. O'Conner, Fort Thomas
Glenn L. Pfister, Fort Thomas

Edmonson
John A. Wilson, Brownsville

Fayette
Ray H. Hayes, Lexington
Harold C. Haynes, Jr., Lexington
Martin P. Kaplan, Lexington
Robert C. Morris, Lexington
Joseph B. Parker, Jr., Lexington
Edmund D. Pellegrino, Lexington
Kenneth S. Phillips, Lexington
Edward H. Ray, Jr., Lexington
James E. Ross, Lexington
Samuel S. Shouse, Lexington
Charles N. Tarkington, Lexington

Floyd
L. C. McCloud, Jr., Martin

Franklin
Abbott B. Mitchell, Frankfort
Edward M. Thompson, Frankfort

Graves
William F. Ruoff, Mayfield

Hardin
Ollie B. Emerine, Elizabethtown
Rex L. Huff, Elizabethtown
David T. Lewis, Elizabethtown
Jorge C. Shpilberg, West Point

Harlan
Howard L. Elliott, Harlan
James W. Gibson, Jr., Harlan
Harold R. Johnson, Cumberland
Mary C. McNeill, Cumberland
Hermann K. Schueler, Harlan
Virginia A. Stevens, Harlan
R. Burke Suitt, Harlan

Henderson
Daniel G. Lareau, Henderson

Hopkins
Herbert Chaney, Dawson Springs
William C. Gardner, Madisonville

Jefferson
Horace W. Addams, Louisville
Ronald C. Almgren, Louisville
Henry I. Berman, Louisville
Clifford L. Berner, Louisville
Richard W. Dame, Louisville
Thurman W. Demunbrun, Louisville
Donald G. Diebold, Louisville
Malcolm H. Fine, Louisville
Norwood K. Ford, Jeffersontown
Harold E. Gasper, Louisville
J. Alex Haller, Jr., Louisville
Don L. Harmon, Louisville
Albert B. Harris, Louisville
Henry G. Jackson, Louisville
Nettie G. King, Louisville
Ferrell C. Lowrey, Jr., Louisville
Lowell R. McClary, Middletown
Donald H. Mosley, Lyndon
Clinton R. Potts, Louisville
Samuel R. Scheen, Louisville
Jack A. Schecter, Louisville
F. P. Shepherd, Louisville
E. F. Smock, Jr., Louisville
Leslie Van Nostrand, Louisville
Will W. Ward, Louisville
Norton G. Waterman, Louisville
Earl B. Williams, Louisville
Elizabeth Woodward, Louisville

McCracken
Edwin T. Davis, Paducah

McCreary
Merrill A. Winchester, Whitley City

Mason
Robert M. Blake, Maysville

Meade
Walter A. Cole, Jr., Brandenburg

Mercer
John S. Baughman, Harrodsburg
Bacon R. Moore, III, Harrodsburg

Morgan
Morris L. Peyton, West Liberty

Ohio
William J. Hanley, Beaver Dam

NEW MEMBERS

(Continued)

Oldham
Hubert F. Sturges, Crestwood

Pendleton
Carl A. Waldemayer, Butler

Pike
Kurt T. Schmidt, Williamsburg

Robertson
D. L. Arnett, Livingston

Shelby
John R. Gleason, Shelbyville
Robert H. Shipp, Shelbyville

Simpson
Paul H. Wilson, Franklin

Warren
Carroll C. Brooks, Bowling Green
Steve C. Cuff, Bowling Green
Nicholas Z. Kapoglis, Bowling Green

Woodford
Norman S. Fisher, Jr., Midway

Dr. Wood Named to Commission For Handicapped Children

Charles F. Wood, M.D., Louisville orthopedic surgeon, is the medical representative on the new seven-member board of the Commission for Handicapped Children, formerly known as the Kentucky Crippled Children Commission. Governor Combs announced the appointments on August 10.

The change in the name of the Commission, which has cared for Kentucky's handicapped children for 35 years, was authorized by action of the 1960 General Assembly, which also provided for the setting up of a seven-man board. Doctor Wood was one of three physicians nominated by KSMA for its representative on the board. His term is for three years.

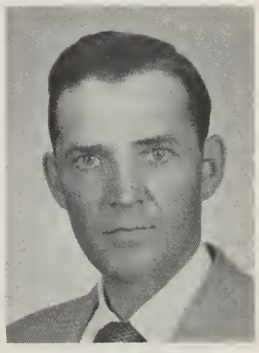
Handicapped children include all crippled children under the age of 21, amenable to medical treatment. No child shall be accepted for care or treatment if his parents or guardian are able to pay for such treatment unless they reside in an area in which treatment is not otherwise available. In cases where parents can pay only a portion of the cost of treatment, the partial payment will be applied to the cost of treatment and care of the child.

About 65 per cent of the present 7000 patients are being treated for orthopedic handicaps, 12 per cent for cerebral palsy, eight per cent for cleft lip and palate, three per cent for plastic conditions and two per cent in the special scoliosis clinic.

Physicians are invited to observe and discuss their patients at the clinics held almost daily in Louisville, weekly in Lexington, and at monthly intervals in Covington, Ashland, and Paducah. There are area field clinics once or twice a year as needed throughout the state in the spring, summer, and fall.

KAGP Appoints Leo E. Hogan As Director of Education

Announcement of the appointment of Leo E. Hogan, a native of Cave City, as director of education for the Kentucky Academy of General Practice was made resently by John Archer, M.D., Prestonsburg, KAGP president.



Mr. Hogan

In his new duties Mr. Hogan will arrange regional symposia and be responsible for promoting increased attendance at these postgraduate sessions. He is a graduate of Bowling Green College of Commerce, Bowling Green, in 1954, with a B.S. in Business Administration.

For the past six years he has been employed by the Department of Revenue, Commonwealth of Kentucky, in various auditing and administrative positions. The past two years he has served as a supervisor. He is married and has one son.

Hospital Assn. Names Director, Opens Louisville Office

The Kentucky Hospital Association has announced the appointment of a full-time executive director and the opening of executive offices in the Kentucky Hotel, Louisville.

The new director is Hasty W. Riddle, 43, retired lieutenant colonel of the U. S. Army, who for the past two years has been hospital administrator at the Army Medical Service School, Fort Sam Houston, Texas, and assistant professor of hospital administration at the Baylor University Graduate School. A native of South Carolina, Colonel Riddle received his B.S. degree from the University of Maryland and his M.H.A. degree from Baylor. His army service was devoted to hospital work.

With the new director expected to report for duty in mid-September, the hospital association has closed its office in Lexington, where Mrs. Elizabeth Zimmerman had been serving as part-time director.

Industrial MD's Plan Lunch

A luncheon for members of the Kentucky Industrial Medical Association has been scheduled during the KSMA Annual Meeting. The group will hold its luncheon meeting on Tuesday, September 20, at 12:15 p.m. in Parlors A, B, and C of the Brown Hotel in Louisville, according to Donald B. Thurber, M.D., secretary.

Digest—Of The Open Meeting Of The KSMA Council On July 28, 1960*

Following the report of the president, the delegate to the AMA, and the giving of the Headquarters Office report, Sam A. Overstreet, M.D., Louisville, was elected editor of the Journal of KSMA for a second two-year term, and George W. Pedigo, M.D., Louisville, associate editor, was also elected for a second two-year term.

KSMA Bylaws Committee was authorized to study the recommendation that all KSMA offices be changed by Bylaws not to exceed a three-year term.

Following the discussion of a recommendation that all KSMA Annual Meeting scientific programs and the scientific programs of councilor district meetings be qualified as acceptable for Category I credit under the American Academy of General Practice, the following motion was passed:

> "At the invitation of the Kentucky State Medical Association, the scientific programs of the _____ Annual Meeting and (as the case may be) councilor district meetings, be prepared with the active cooperation and assistance of the specialty groups listed below and presented by the Association under their cosponsorship. It will be permissible for the following to appear in fine print and inconspicuously on the program: 'This program is acceptable for _____ hours of Category I AAGP credit'."

The Council then accepted a recommendation from the KSMA Associate Committee on Insurance: (1) that the committee be authorized to serve as a clearing house to handle complaints by insurance companies against physicians and complaints by physicians against insurance companies; (2) that the Council ask the Legislative Committee to study the desirability of proposing legislation to require certain standard provisions for health and accident policies; and (3) that a statement be approved on bad practices.

The appeal of the Society of Medicine, Pike County, for a charter was considered. Following discussion, the appeal was not accepted; the decision being based on Chapter XII, Section 4 of the Bylaws.

Members of the Council were told that Resolution K related to a recommendation that an investigation be conducted to learn if there were any irregularities concerning the "code of conduct of physicians and osteopaths who might be engaged in the corporate or unlicensed practice of medicine, by reason of their connection with hospitals." The House of Delegates had voted to send this resolution to the state societies of radiology, pathology and anesthesiology, with the request that this resolution be studied and recommendations be received. The June 30 Executive Committee of the Council reviewed the studies of the Association and referred them to the KSMA Committee on Third Party Medicine.

This committee studied the recommendations of the three groups and made the following recommendation to the Council, which the Council accepted: "It appears from the responses of the three specialty groups (anesthesiologists, pathologists, and radiologists), that it is not expedient at this time for the Association to undertake to solve these problems by litigation. It is the recommendation of this committee that the possibility of sponsoring a professional practice act (as recommended by past-president Mersch) be explored."

The Council heard the recommendation of the Legislative Committee which stated that while the key-man system had been working on the whole very well, there were certain weak spots which needed revamping. After discussion, the Council voted to authorize the Legislative Committee to make the proposed recommendations for the rebuilding of the system and report back to the Council.

There was then a discussion of Senate Bill 3570, Second Session, 86th Congress, which was described as the antivivisectionist bill and which was introduced by Senator John Sherman Cooper and others. Following the discussion, the Council went on record as opposing the bill in toto.

The Commissioner of Health, Russell Teague, M.D., Frankfort, told of the progress that was being made in setting up the new indigent medical care program passed by the Legislature at its 1960 session. He noted the important part that physicians played in making the program a success.

At the March 30 meeting of the Council in Owensboro, the report of the Committee on Medical Education and Economics concerning the relative value study was discussed. Since the Council did not act at that time, on the recommendation, it was again discussed at the July 28 meeting. When it was learned that there was relatively little interest in the subject, a motion to table the matter at this time passed.

The Council was told that the date of the Officers Conference had been set for April 6, 1961, and that it would be held at the Phoenix Hotel in Lexington.

The Council also decided to hold the fourth annual dinner honoring Kentucky's senators and congressmen in Washington on Thursday, February 23.

The Council voted to ask the president and the chairman of the Council to appoint a membership committee which would have two objectives: (1) making sure that all plysicians who should be members would have an opportunity to join KSMA, and (2) increasing the membership in the American Medical Association.

The Council also voted to authorize its chairman to appoint a committee to study the Jefferson County Armory as a possible meeting place for the KSMA Annual Meeting. It was learned that the Jefferson County government planned to spend $670,000 in renovating the building.

**As authorized by the 1956 session of the House of Delegates, the Journal is presenting a digest of the minutes of the July 28 meeting of the Council of KSMA.*

In Acute Illness...

NILEVAR®

Can Speed Recovery

"Commonly, negative nitrogen balance[1] occurs during acute febrile illnesses and following traumatic events and surgical procedures." As much as 300 to 400 Gm. of nitrogen[2] may be destroyed daily in severe infections. Convalescence[1] is delayed when negative nitrogen balance is large and persistent.

NILEVAR Builds Protein, Speeds Convalescence to Complete Recovery[3-6] ". . . we were impressed[3] with the efficacy of Nilevar as an anabolic agent. All of the patients reported feeling much more vigorous and experiencing an increase in appetite. . . ."

The actions of Nilevar[4] in reversing a negative nitrogen balance—and therefore a negative protein balance—improving the appetite and increasing the sense of well-being can be expected to shorten the illness and the convalescence of these patients.

An initial daily dosage of 30 mg. of Nilevar (brand of norethandrolone) is suggested. After one to two weeks, this dosage may be reduced to 10 or 20 mg. daily in accordance with the response of the patient. Continuous courses of therapy should not exceed three months, but may be repeated after rest periods of one month. Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil with benzyl alcohol.

1. Eisen, H. N., and Tobochnick, M.: Protein Metobolism, M. Clin. North America 39:863 (May) 1955. 2. Jomison, R. M.: Generol Nutritive Deficiency, Virginia M. Month. 83:67 (Feb.) 1956. 3. Goldforb, A. F.; Nopp, E. E.; Stone, M. L.; Zuckermon, M. B., and Simon, J.: The Anobolic Effects of Norethondrolone, o 19-Nortestosterone Derivotive, Obst. & Gynec. 11:454 (April) 1958. 4. Botson, R.: Investigotor's Report, Feb. 11, 1956. 5. Weston, R. E.; Isoocs, M. C.; Rosenblum, R.; Gibbons, D. M., and Grossmon, J.: Metobolic Effects of on Anobolic Steroid, 17-Alpho-Eithyl-17-Hydroxy-Norondrostenone, in Humon Subjects, J. Clin. Invest. 35:744 (June) 1956. 6. Brown, C. H.: The Treotment of Acute and Chronic Ulcerotive Colitis, Am. Proct. & Digest Treot. 9:405 (Morch) 1958.

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Research in the Service of Medicine



Louisville Orthodontist Named To State Board Of Health

The dental profession for the first time has a representative on the Kentucky State Board of Health, under a law passed by the 1960 General Assembly. He is John A. Atkinson, D.M.D., Louisville orthodontist, who was appointed to the board by Governor Combs in August.



Dr. Atkinson

Doctor Atkinson, one of three dentists whose names were submitted by the Kentucky Dental Association, was president of the state dental group in 1955-56 and president of the Southern Society of Orthodontists in 1957-58. He has also served as president of the Louisville District Dental Society.

Doctor Atkinson's appointment brings the Health Board's membership to 10. Heretofore there have been nine members: six licensed physicians, one registered pharmacist, one licensed osteopath and the Commissioner of Health, who serves as ex officio member.

Ira Wallace Elected President Of Geriatrics Society

Ira O. Wallace, New Castle, was elected president of the National Geriatrics Association at its seventh annual convention in Miami.

A past president of the Kentucky Nursing Home Association and the American Nursing Home Association, Mr. Wallace has been in hospital work since 1935. He is the owner of the New Castle Sanitarium.

He has been a director of the National Joint Council to Improve the Health Care of the Aged since it was established in 1958. Mr. Wallace was also on the planning committee of the first National Conference on Nursing Homes and Homes for the Aged.

J. J. Thompson Installed Head Of Kentucky Pharmacists

J. J. Thompson, South Fort Mitchell, was installed as president of the Kentucky Pharmaceutical Association at the group's annual meeting in French Lick, Ind., on July 25. The meeting was attended by 375 pharmacists of the state.

Mr. Thompson, formerly chairman of the board, succeeded E. Crawford Meyer, Louisville, as president of the association. E. Murphy Josey, Frankfort, was re-elected secretary and R. W. Leake, Danville, was named chairman of the board.

One of the actions taken at the meeting, which will be of interest to physicians, was the following resolution:

WHEREAS the American Medical Association, in convention assembled at Miami Beach, Florida, adopted a statement of policy on the unorthodox practice of prescription service by mail order plan, and

WHEREAS this statement of policy condemned mail order prescription plan,

THEREFORE BE IT RESOLVED that the Kentucky Pharmaceutical Association express its thanks to the American Medical Association for the position they have taken on mail order prescription.

BE IT FURTHER RESOLVED that the Kentucky State Medical Association be asked to take a similar position of condemning the practice.

Dr. Harter Speaks In Vienna

John Harter, M.D., Louisville, governor for Kentucky of the American College of Chest Physicians, attended the Sixth International Congress of Chest Physicians in Vienna, August 27-September 1. He was scheduled to present a paper on cancer cells and peripheral blood and to appear on the platform at the opening and closing convocations.

Doctor Harter also attended a meeting of the International Committee for Pulmonary Surgery, served as chairman of one of the fireside conferences held in connection with the Congress, and participated in a free discussion session. Before returning home, Doctor Harter and his wife, who accompanied him to Europe, will spend some time touring Switzerland, Italy, Spain, Portugal and France.

Lexington Clinic Sets Fall Conference Oct. 27

The Lexington Clinic has announced its Fifth Fall Clinical Conference for Thursday, October 27, at the clinic, 1221 South Broadway, Lexington. This year's sessions are limited to one day.

I Practical Gynecology

Endometriosis ..... F. M. Massie, M.D.
Estrogens After the Menopause .... J. B. Selby, M.D.
Experiences With Papanicalaou Studies ..... C. N. Tarkington, M.D.

II Symposium on Viral Diseases

Viral Hepatitis ..... D. H. Johnston, M.D.
Viral Diseases of the Central Nervous System .....N. T. Macfarlane, M.D.
Laboratory Aids In Diagnosis ..... A. Balows, Ph.D.
Immunization Procedures .... N. T. Macfarlane, M.D.

Luncheon Round-Tables

1. Gynecology
2. Viral Diseases

III The Convulsion As a Symptom

The Convulsion ..... L. W. Blakey, M.D.
Surgical Procedures—Diagnostic and Therapeutic ..... P. H. Jones, M.D.
Medical Conditions In Which Convulsions Appear As a Symptom .....W. P. Wharton, M.D.

IV Symposium On Practical Therapy

A. L. Cornish, M.D., Moderator


Trancopal®
brand of chlormezanone
effective oral skeletal
muscle relaxant
and tranquilizer
LETS THE PATIENT WALK
"HEADS UP"
in spite of torticollis.



Trancopal

relieves pain and spasm associated with torticollis.

In a recent study by Ganz, Trancopal brought considerable improvement or very effective relief to 20 of 29 patients with torticollis.[1] "The patients helped by the drug," states Ganz, "were able to carry the head in the normal position without pain." Similarly, Kearney found that in 8 of 13 patients with chronic torticollis treated with Trancopal improvement was excellent to good. ". . . Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available."[2]

Lichtman, in a study of patients with various musculoskeletal conditions, noted that 64 of 70 patients with torticollis obtained excellent to good relief with Trancopal.[3]

In a comparative study of four central nervous system relaxants, Lichtman reports that 26 of 40 patients found Trancopal to be the most effective drug.[3]

1. Ganz, S. E.: *J. Indiana M.A.* 52:1134, July, 1959. 2. Kearney, R.: *Current Therap. Res.* 2:127, April, 1960. 3. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 58.

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Clinical results with Trancopal®[2]

	Excellent	Good	Fair	Poor	Total
LOW BACK SYNDROMES					
Acute low back strain	25	19	8	6	58
Chronic low back strain	11	5	1	1	18
"Porters' syndrome"*	21	5	1	1	28
Pelvic fractures	2	1	—	—	3
NECK SYNDROMES					
Whiplash injuries	12	6	2	1	21
Torticollis, chronic	6	2	3	2	13
OTHER MUSCLE SPASM					
Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
TENSION STATES	18	2	4	3	27
TOTALS	112 (51%)	70 (32%)	23 (10%)	15 (7%)	220 (100%)

*Over-reaching in lifting heavy bags resulting in sprain of upper, middle, and lower back muscles.

Dosage: **Adults, 200 or 100 mg. orally three or four times daily.**
Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

How Supplied: Trancopal Caplets®
200 mg. (green colored, scored), bottles of 100.
100 mg. (peach colored, scored), bottles of 100.

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Farm-City Week Nov. 18-24 To Be Given Boost At State Fair

With Farm-City Week set for November 18-24, the National and State Farm-City Week committees again have invited all state and county medical societies to join in a program to "build better relationships between town and country neighbors."

Lieutenant Governor Wilson W. Wyatt is slated to kick off the Kentucky observance by appearing on a special program September 12 at the Kentucky State Fair. C. H. Fields, editor of the Kentucky Farm Bureau News, is the state campaign chairman and also regional chairman for the three-state area—Kentucky, Tennessee and West Virginia.

As in the past three years, the observance will be conducted nationally and locally by hundreds of civic, industrial, agricultural, professional and youth organizations. Kiwanis International was instrumental in starting Farm-City Week and provides space today for the headquarters office.

The American Medical Association has a member on the Farm-City Board of Directors, and the AMA urges component state medical associations and their county medical societies to participate actively in this year's close-neighbor program.

Blue Cross-Shield Plan Leads Federal Worker Enrollment

Blue Cross-Blue Shield led all other organizations in enrollment of government workers who became eligible for coverage under the Federal Employee Health Benefits legislation enacted last year, the national associations have reported from Chicago.

Nearly complete tabulations indicated that some 935,000 of the estimated 1,695,000 federal employees who selected health benefits coverage from among 38 programs available chose Blue Cross-Blue Shield. This was compared to 450,000 enrolled by the Aetna Life Insurance Company. All other programs, including those offered by government employee and group health organizations, accounted for but 19 per cent of the total enrollment.

A breakdown of enrollment totals showed that government employees preferred the high level-higher cost benefits program over the low benefit-lower cost option offered by Blue Cross-Blue Shield by a ratio of about four to one. This indicates they share with the public at large a desire to have a comprehensive degree of coverage, a spokesman for the Plan said.

Committee Plans Open Meeting

The KSMA Committee on Maternal Mortality is planning an open meeting in the Derby Room of the Brown Hotel immediately after lunch on Tuesday, September 20. All KSMA members are invited to attend. The meeting will follow a luncheon for the committee scheduled for from 12 noon to 12:30 p.m. Robert Monroe, M.D., Louisville, is committee chairman.



Owen B. Murphy, Jr., M.D., Lexington, (right), a participant in the Athletic Injuries Conference, discusses knee injuries with Bill Welborn, head football coach at Madisonville High School. The half-day conference was attended by 141 coaches and others interested in the prevention and treatment of athletic injuries.

KSMA Athletic Injury Prevention Conference Draws 141

Attendance of 141 was recorded at KSMA's second Conference on Athletic Injury Prevention, held Saturday, August 13, in Lexington. This compared to 125 at the first conference in 1959.

A spirited discussion period, with audience participation, was a feature of this year's program. Carroll L. Witten, M.D., Louisville, served as chairman of the meeting, and the speakers were Owen B. Murphy, Jr., M.D., and John B. Floyd, Jr., M.D., both of Lexington, and Paul J. Ross, M.D., and Clinton R. Potts, M.D., Louisville. Ted Sanford, Commissioner of the Kentucky High School Athletic Association, gave the official welcome.

Cooperating with KSMA in presenting the conferences are the Kentucky High School Athletic Association, Kentucky Advisory School Health Council and University of Kentucky Athletic Association.



Looking over the conference program is Carroll L. Witten, M.D., Louisville, (left) chairman of the Athletic Injuries Prevention Conference, and Ted Sanford, Kentucky High School Athletic Association Commissioner.

Heart Association Gives $104,275 For Program In State

Grants totaling $104,275 for heart research and other heart programs in the state have been announced by the Kentucky Heart Association and its chapters. Continued support of the chair of heart research at the University of Louisville School of Medicine, filled by Joseph P. Holt, M.D., is included.

The research grants are as follows—all at the U. of L. except where noted:

Chair of heart research, $15,900; *18 student-research scholarships,* $11,250; *study of coagulation in heart-disease patients,* Thomas D. Stevenson, M.D., $5,200; *study of children with congenital heart disease,* Frank T. Falkner, M.D., $2,750;

Study of fatty substances isolated from the blood, Robert S. Levy, M.D., $4,705; *study of the spleen in X-ray irradiation of animals,* K. C. Huang, M.D., $1,750; *cholesterol levels in the blood,* Maurice Best, M.D., $4,800; *sensitivity of white blood cells in rheumatic fever,* Morris Scherago, M.D., of the University of Kentucky, $2,100;

Studies of effects of magnesium deficiency on the hearts of rats, Herbert K. Kashiwa, $5,000; *role of metals and organic compounds in kidney function,* Peter K. Knoefel, $2,400; *effects of stress on the biochemistry of the heart muscle,* Frederick K. Hilton, M.D., $2,590.

The money for the grants came from the $340,000 collected in the annual Heart Fund campaign in February.

New State Regulation On Returning Prescription Drugs Explained

To help clear up some confusion about a recent regulation adopted by the State Board of Health relating to the return of prescription drugs, Commissioner of Health Russell E. Teague, M.D., has sent the Journal a copy of the ruling. It specifies:

No apothecary, pharmacy, pharmacist, or agent thereof shall accept for reuse or resale a prescription of any drug in which the original package containing same has been broken or when the drug requires refrigeration or when any package of a prescription drug has been retained by the buyer for a period of fourteen days or more from the date of the sale. This regulation shall not apply in the case of hospital pharmacies where drugs are not issued directly to the patient.

The regulation was adopted and issued pursuant to Sections 211,090 (1) (d) and 211,180 of the Kentucky Revised Statutes, and Sections 13 and 14 of Chapter 247 of the 1960 Acts of the General Assembly.

AGS Elects Dr. McCarty

A. Clayton McCarty, M.D., Louisville, was elected president-elect of the American Geriatrics Society at the group's 17th annual convention in Miami Beach. He served as a vice-president of the society the past year.

Doctor McCarty is chairman of the KSMA Associate Committee on Problems of the Aged.

U. of L. Announces Faculty Changes At Medical School

A number of faculty changes at the University of Louisville School of Medicine have been announced recently by the university trustees.

Promotions of medical school staff include: Joseph A. Little, M.D., to professor of pediatrics; Cathryn Handelman, M.D., Nathan Handelman, M.D., Martin Z. Kaplan, M.D., and Elliott Podoll, M.D., to assistant professors of pediatrics; and Louis Peskoe, M.D., and Danial N. Pickar, M.D., to associate professors of medicine.

Newly appointed staff members include: Donald M. Thomas, M.D., instructor in anesthesiology; Glenn R. Stoutt, Jr., M.D., and Nan Elizabeth Robinson, M.D., instructors in child health; Nina Kateryniuk, M.D., and Elizabeth Woodward, M.D., instructors in psychiatry; Norton G. Waterman, M.D., instructor in surgery; Mary Eileen Denison, Ph. D., and Robert L. Jasper, Ph. D., research associates in medicine; James E. Price, Ph. D., lecturer in social sciences; and Bruce M. Anderson, Ph. D., instructor in biochemistry.

Dr. Adams Leaving U. of L.

William C. Adams, M.D., assistant professor of pediatrics at the University of Louisville School of Medicine, is leaving the university after six years as an instructor. He will go to Miami about October 1 to become associate professor of pediatrics at the University of Miami Medical School and medical director of Variety Children's Hospital.

Doctor Adams, who also is chief of pediatrics at Louisville General Hospital, is co-ordinator of the Louisville Poison Control Program, which he set up in the pediatrics department in 1955; a member of the executive committee of Kentucky Poison Control Centers, and a special consultant to the United States surgeon general on accident prevention. He teaches pediatrics at the U. of L. Dental School and social-work aspects of medicine at the Kent School of Social Work. Doctor Adams is a 1947 graduate of Temple University Medical School, Philadelphia.

Dr. Cruise Resigns U. L. Post

Mary O. Cruise, M.D., assistant professor of child health at the University of Louisville School of Medicine and a member of the staff of Louisville General Hospital, has resigned to accept a post as assistant professor of pediatrics with the University of Buffalo Medical School. Her resignation becomes effective October 1.

Doctor Cruise received her medical degree from George Washington University, Washington, in 1943 and was a medical missionary in the Philippines from 1946 to 1949. Before joining the U. of L. Medical staff in 1955, she was pediatric consultant for the Mississippi State Board of Health and also an instructor in pediatrics at Tulane University Medical School.

Committee Reports

Associate Committee on Insurance

John Dickinson, M.D., Chairman

Louisville **June 16, 1960**

The committee noted the tremendous growth in voluntary health insurance and that the majority of companies were reputable and issuing good coverage. However, it was mentioned that some companies were resorting to deplorable tactics in selling substandard coverage.

In this the first meeting of the year, it was voted to recommend to the KSMA Council that the committee be authorized to function as a clearing house to handle grievances between the insuring companies and physicians. This committee would not handle complaints between patients and the insurers.

It was further recommended to the Council that a statement listing and condemning some of the bad practices in the insurance industry be sent to the Health Insurance Association of America and the Department of Insurance, Commonwealth of Kentucky, Frankfort.

A report was also made on the general acceptance of the KSMA simplified insurance form and it was stated that requests for copies of the form are coming from all parts of the country.

Three On U. L. Medical Staff Receive Research Grants

Research grants to three faculty members at the University of Louisville School of Medicine have been announced recently.

William M. Christophersen, M.D., professor and chairman of the Department of Pathology, will make a three-year study of human-body cells under a $38,652 grant from the National Institutes of Health. A possible result of the study would be to help determine whether leukemia is really a malignant disease or a nutritional or metabolic disease, Doctor Christophersen said.

William J. Hockaday, M.D., assistant professor of psychiatry and associate in surgery, has received a fellowship for research in clinical medicine from the American Philosophical Society, Philadelphia. He will study what parts of the brain are involved in learning and memory. The grant is for $7,000 the first year and, if approved for two more years as expected, will provide $8,000 the second year and then $9,000.

Arland T. Hotchkiss, M.D., associate professor of biology, was awarded $6,200 from the National Science Foundation to study cell structure of green algae, which is found in the Ohio River.

While at the Annual Meeting . . . .

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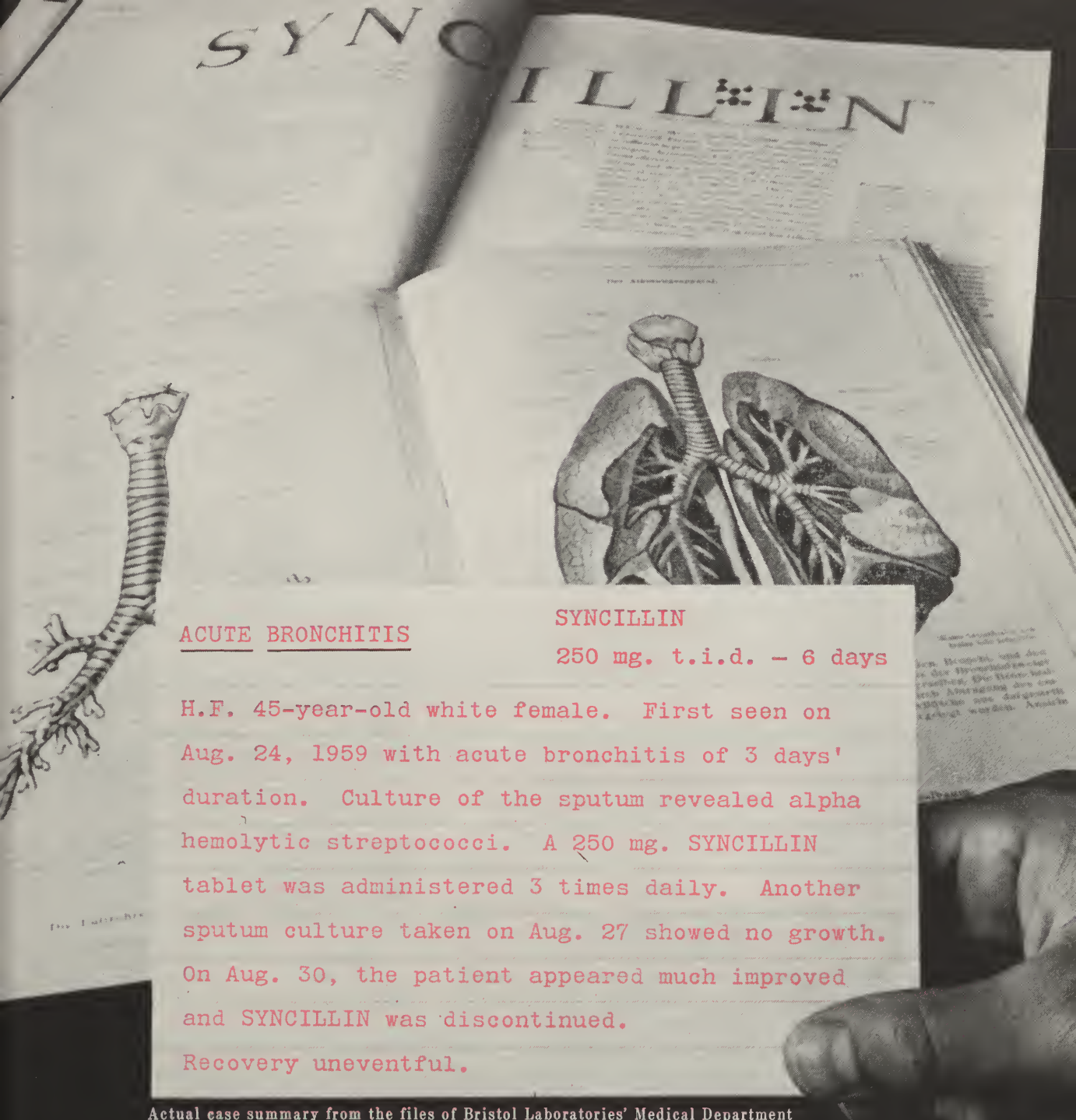
JUniper 3-1933 is the special KSMA number at Columbia Auditorium at the KSMA Headquarters Office, where all general scientific sessions will be held.

JUniper 3-0115 is the special number for physicians attending meetings at the First Christian Church. If you plan to attend either of five specialty group sessions or seven reference committee meetings at First Christian Church Tuesday afternoon, September 20—only—call JU 3-0155.

Or, if you plan to attend any of the five specialty group meetings at First Christian Church Thursday morning, September 22, only—call JU 3-0115.

Do not call the First Christian Church number! Call our official number at the Church JU 3-0115.

JUniper 4-1311 (Extension 92) is the special number to be called if you want to be reached either Monday evening, September 19, or Wednesday evening, September 21, while attending the meetings of the KSMA House of Delegates in the Roof Garden of the Brown Hotel.



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Ob-Gyn Course In Louisville Nov. 9-10 Second In Series

A two-day course in Obstetrics and Gynecology, set for November 9 and 10 in Louisville, is announced as the second of a series of programs planned by the KSMA Postgraduate Medical Education Committee to serve the general practitioners in various sections of the state. The first, a two-day course in chronic disease, is scheduled for October 19 and 20 in Bowling Green.

These and other postgraduate medical opportunities in Kentucky and adjoining states for the next three months are included in a listing supplied by the KSMA Postgraduate Medical Education Office. More detailed information may be obtained by writing to the office, 104 West Chestnut Street, Louisville 2, or calling JUniper 7-7135.

The complete listing follows:

September

12-17 Postgraduate course, "Recent Advances in Clinical Practice," University of Buffalo School of Medicine, Buffalo, N. Y.

20-22 KSMA Annual Meeting, Columbia Auditorium, Louisville.

20 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

26-27 Tennessee Valley Medical Assembly, Read House, Chattanooga; For information, contact Dr. Robert A. Waters, 109 Medical Arts Building, Chattanooga, Tenn.

26-30 "Anesthesia for the General Practitioner," a five-day postgraduate course offered by the University of Tennessee College of Medicine, Memphis.

October

7 Postgraduate course, "Physical Medicine," a short course sponsored by the University of Nebraska College of Medicine, Omaha.

10-14 "Postgraduate Course in Radiology," University of Tennessee College of Medicine, Memphis.

17-29 Postgraduate course, "Laryngology and Bronchoesophagology," sponsored by the University of Illinois College of Medicine, Department of Otolaryngology, under direction of Paul H. Holinger, M.D.; limited to 15 physicians. Register at the university, 1853 West Polk Street, Chicago 12, Ill.

18 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

19-20 Postgraduate course, "Chronic Diseases," with scientific lectures, panel discussion and question period; sponsored by Kentucky State Department of Health, KSMA Postgraduate Medical Fund, U. of L. School of Medicine and U. of K. Medical Center; Ole Fort Restaurant, Bowling Green, Ky.; 2 p.m. Category I credit applied for. No fees.

19-20 Louisville Society of Internists, postgraduate meeting; Louisville.

20-22 Southern Medical Association, meeting; Hilton Hotel, El Paso, Texas.

27 Fifth Annual Fall Clinical Conference of the Lexington Clinic, Lexington. General subjects: "Practical Gynecology," 'Symposium on Viral Diseases," "The Convulsion As a Symptom," and "Symposium on Practical Therapy."

29 Kentucky Chapter of the American College of Physicians, regional meeting; Lexington.

November

3-4 Postgraduate Course "Allergy," University of Tennessee College of Medicine, Memphis.

9-10 "Postgraduate Course in Ob-Gyn," sponsored by the KSMA Postgraduate Medical Office, Kentucky State Department of Health, University of Louisville, University of Kentucky and the Kentucky Academy of General Practice; Kentucky Hotel, Louisville, 10 a.m.; no fees; limited to 50 persons.

15 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, State Tuberculosis Hospital, District 2, Louisville.

17 Postgraduate Course, "Neurology and Psychiatry in General Practice," University of Nebraska, College of Medicine, Omaha.

December

14 John N. Norton Memorial Infirmary Medical Seminar; postgraduate course; John N. Norton Memorial Infirmary, Louisville.

20 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

KAGP Sets Two October Seminars

The Kentucky Academy of General Practice has announced the following dates for its next two seminars:

October 6—Ken-Lake Seminar; Thornton E. Bryan, Jr., M.D., Cadiz, chairman.

October 13—Maysville Seminar; George Estill, M.D., Maysville, chairman.

Dr. Troutman Speaks At Bedford

Woodford B. Troutman, M.D., Louisville, secretary of KSMA, addressed a joint meeting of the Rotary Clubs of Bedford, Ky., and Madison, Ind., at Bedford on August 3. He spoke on "Providing Medical Care for the Aged." Doctor Troutman was introduced by Carl Cooper, M.D., Bedford.

Student AMA

How shall the nation be supplied with adequate numbers of well qualified physicians? This was the specific query that a 22-man Consultant Group on Medical Education appointed by the Surgeon General of the United States set out to answer.

The products of their research were included in the Bane Report which was published in October, 1959. This report does an excellent job in highlighting and documenting the fact that the existing and projected medical training facilities cannot provide for the physicians this country will need by 1975. This contention is based upon the assumption that if the population of the United States increases as expected there will be 235,000,000 people in this country by 1975 and that this would require 300,000 physicians if the present physician-population ratio is to be maintained (141 physicians/10,000 population).

In order to provide 300,000 physicians by 1975, our rate of graduating physicians would have to increase from 7,400/year to 11,000/year by that time. No presently existing medical training facilities can provide these 11,000 new physicians yearly by 1975. Certainly these data insist upon the increase and expansion of existing medical training facilities.

Quite naturally, the biggest drawback concerned with solving this national health problem is obtaining the necessary capital. There are many indications that the future will only add to the complexity of financial problems facing medical education.

The staggering wall of rising costs, the increasing awareness of and demand for adequate medical facilities by the average American citizen, the professional and social needs for more specially-trained physicians and medical scientists, and the ever expanding population are only a few of the very realistic reasons for being concerned and for seeking a reasonable solution.

The previously mentioned Consultant Group calls this "A national health problem, a need of the whole people. The provision of the needed support is without question a national responsibility."

Like many others, this reader finds it very difficult to ignore the obvious implication of this statement—that the provision of the needed support may be considered a prerogative of the Federal Government. I am confident that there are few people who would welcome government owned and operated medical schools; other alternatives and sources of support surely are not yet exhausted.

It pleases me to see Kentucky take a positive step in answer to this national problem—the new Medical School at Lexington, Kentucky.

To the faculty, staff and students of this new institution, the University of Louisville School of Medicine, your 123-year-old friend, bids you welcome. Kentucky medicine has a distinguished history with a tradition of excellence that I'm sure will be enhanced by your presence.

Barney E. Elliott, Jr.
President, Student AMA
U. of L. School of Medicine.

Editor's Note: Other new officers of the SAMA Chapter at the U. of L. are: Olson Huff, vice-president, and Rollin Burhans, secretary-treasurer.

Malaria Control In Thailand Gets Assist From Kentuckian

Joseph Miles Butler, M.D., of Paducah is back in the United States on leave after spending five years in Thailand as a malaria control adviser with the International Cooperation Administration.

Doctor Butler's major role in Thailand's malaria eradication program is described in an ICA news release. When the Kentucky-born physician was sent to Chiengmai in 1955, the work of malaria research and control was being carried on from three Quonset huts. He supervised construction of a new institute, including laboratory, library, administrative offices, technicians' quarters and other necessary buildings. Training was provided for doctors and technicians.

By the end of 1958, the homes of more than 12 million Thais had been sprayed with insecticides. This year, field teams are making a house-to-house search for cases of malaria.

Correction

In the Journal's special article for July, entitled "A Contrast and a Plea," relative to Kentucky's new indigent-care program, it was inadvertently stated that a county review committee will decide "the scope of the local program." The duty of the committee is to see that funds provided for medical care are not misused and abused at the local level.

New State Lab To Open Nov. 1

Opening of a new occupational-health laboratory at the State Department of Health in Frankfort is scheduled for November 1, Norman E. Schell, director of the Division of Occupational Health, has announced. It will be equipped to test gases, solvents, dust and other agents causing occupational diseases and also to test physical hazards, such as noises that could cause hearing loss, plus lighting, color and radiation.

The new laboratory will have 4,600 square feet of space, as compared to 600 square feet in the one at the old Department of Health building in Louisville, Mr. Schell said. Already, about $100,000 has been spent on instruments to equip it.

Public Health Laboratories Moved

The Public Health Laboratories, formerly located at 620 South Third Street, Louisville, were moved August 15 to Frankfort. The State Department of Health has issued a notice that all specimen containers should be sent to the new address: 275 East Main Street, Frankfort.

NEWS ITEMS

Wallas N. Bell, M.D., is now in general practice in Sturgis. He was graduated from the University of Louisville School of Medicine in 1959 and recently completed his internship at St. Louis City Hospital. Doctor Bell is a native of Sturgis.

George Russell Bellamy, M.D., is associated in general practice with **H. B. Murray, M.D.,** in West Liberty. Doctor Bellamy received his M.D. degree from the University of Louisville School of Medicine in 1957, interned at St. Albans Naval Hospital, L. I., N. Y. He just completed three years of duty as a lieutenant in the U. S. Navy.

Leon Wilson Bowman, M.D., a 1959 graduate of the University of Louisville School of Medicine, is now in general practice in McKee. Doctor Bowman, a native of Booneville, interned at City Hospital, Springfield, Ohio.

William D. Bushong, M.D., has opened an office in Glasgow where he will limit his practice to pediatrics. Doctor Bushong was graduated from the University of Louisville School of Medicine in 1957. He interned at Louisville General Hospital and took his residency training at Children's Hospital in Louisville.

James E. Butler, M.D., has begun the practice of medicine in Lexington in association with Robert M. Sirkle, M.D. Born in Paintsville, Doctor Butler received his M.D. degree from the University of Louisville School of Medicine in 1956, interned in a hospital at Jacksonville, Fla., and took residency training in general surgery in Miami. He served four years, 1956-60, in the U. S. Navy, attaining the rank of lieutenant.

Carl T. Clark, M.D., Lexington, has been appointed Fayette County Physician. He previously was in general and industrial practice in Iaeger, W. Va. Born in Greensburg, Doctor Clark was graduated from the University of Louisville School of Medicine in 1931. He took his internship at Louisville General Hospital.

Harold E. Kleinert, M.D., Louisville, has announced that **Robert G. Cooper, M.D., D.M.D.,** has become associated with him and will limit his practice to plastic, reconstructive and maxillo-facial surgery. Doctor Cooper was graduated from the University of Louisville School of Medicine in 1952 and interned at Brooke Army Hospital in San Antonio, Tex. He took residency training in general surgery at the VA Hospital, Louisville, and did residency work in plastic surgery at Washington University and Barnes Hospital, St. Louis.

John C. Davenport, M.D., is now in general practice in Paris, Ky. A 1959 graduate of the University of Louisville School of Medicine, he recently completed his internship at St. Joseph Infirmary, Louisville.

John E. Dawson, M.D., Southgate, will be honored by the Fort Thomas Lodge of Masons at a dinner meeting September 30 in the Fort Thomas Masonic Temple. Doctor Dawson, a past master of the lodge, is deputy grand master for the 29th State Masonic District which embraces 17 Blue lodges in northern Kentucky.

Cleto Elequin, Jr., M.D., a native of the Philippines, has joined the staff of Eastern State Hospital, Lexington, as a psychiatrist. Doctor Elequin was graduated from Far Eastern University, Manila, in 1957. He interned at Good Samaritan Hospital, Lexington, and took his residency training at Central Baptist Hospital, Lexington, and at Danville State Hospital, Danville, Pa.

Malcolm H. Fine, M.D,, who graduated from the University of Louisville School of Medicine in 1959, has started in general practice (excluding obstetrics) in Louisville. He interned at Louisville General Hospital in 1959-60.

Wayne Franz, M.D., and **Paul Kleykamp, M.D.,** have announced that **Eugene Slusher, M.D.,** a native of Beverly, has become associated with them in the general practice of medicine in Ashland. Doctor Slusher was graduated from the University of Louisville School of Medicine in 1959 and has just completed a year's internship at Louisville General Hospital.

R. Glenn Greene, M.D., a native of Nashville, Tenn., has opened an office in Owensboro where he will limit his practice to internal medicine. Doctor Greene is a 1954 graduate of Vanderbilt University Medical School. Following internship and residency training at Vanderbilt University Hospital and two years of army duty, he was a fellow in endocrinology at Barnes Hospital, St. Louis, Mo., for a year.

Thomas L. Heavern, Jr., M.D., has located in Fort Thomas where he will limit his practice to pediatrics. He is practicing in association with **Earl J. Farrell, M.D.,** and **Fred A. Stine, M.D.** A graduate of the University of Louisville School of Medicine in 1957, he interned at St. Elizabeth Hospital in Covington and took his residency training at Children's Hospital in Louisville.

James E. Johnson, Jr., M.D., has become associated in practice with **James L. Salmon, M.D.,** in Madisonville. A general practitioner, he was graduated from the University of Tennessee Medical School and interned at Roanoke Memorial Hospital.

Wallace M. King, M.D., is in the general practice of medicine in association with **James P. Winn, M.D.,** Ashland. Doctor King was graduated from the University of Louisville School of Medicine in 1959 and interned at Kentucky Baptist Hospital, Louisville.



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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

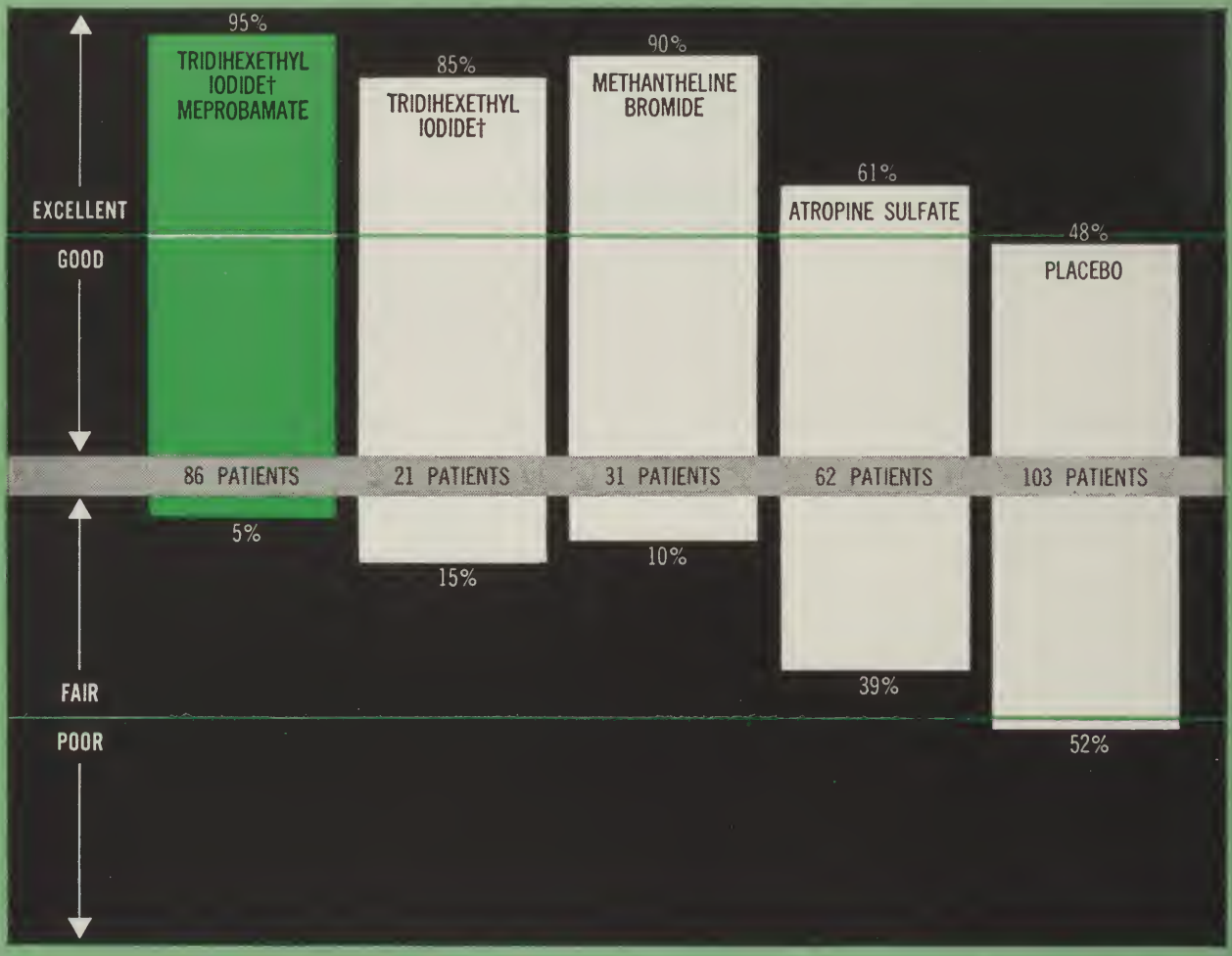
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DRY MOUTH	1%	5%	72%	46%	5%
STOMATITIS	1%	0%	28%	14%	0%
VISUAL DISTURBANCES	0%	0%	50%	34%	1%
URINARY RETENTION	0%	0%	18%	11%	1%
DROWSINESS	20%	0%	0%	0%	0%
COMPLICATIONS OR SURGERY					
HEMORRHAGE	0%	9%	3%	9%	10%
PERFORATION	0%	0%	0%	6%	0%
OPERATION	0%	5%	5%	14%	2%
RECURRENCES					
NONE	28%	23%	25%	17%	26%
FEWER AND MILDER	67%	62%	52%	37%	24%
SAME OR MORE	5%	15%	23%	46%	50%

*Atwater, J. S., and Carson, J. M.: Therapeutic Principles in Management of Peptic Ulcer. **Am. J. Digest. Dis.** 4:1055 (Dec.) 1959.

†PATHILON is now supplied as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could distort the results of certain thyroid function tests.

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NEWS ITEMS

Thomas C. Lane, M.D., is now in general practice in Fulton in association with **Doctors Ward and Glynn Bushart.** Doctor Lane was graduated from the University of Tennessee Medical School in 1958. He took his internship and residency training at Baroness Erlanger Hospital, Chattanooga. One year of his training was in general surgery.

James O. Nall, M.D., who has been practicing in Marion, announces the change of his office address to 310 North 4th Street, Paducah.

W. F. Owsley, M.D., Burkesville, marked his 81st birthday July 22 and was honored by the First Christian Church of Burkesville the following Sunday. Doctor Owsley is the oldest practicing physician in Cumberland county.

Clinton R. Potts, M.D., has started the practice of obstetrics and gynecology in association with **Douglas L. Gillim, M.D.,** in Louisville. After taking his internship training at St. Joseph Infirmary, Louisville, he completed a four-year residency in obstetrics and gynecology at Ohio State University.

William H. Powers, M.D., has started the practice of obstetrics and gynecology in Louisville in association with **J. B. Marshall, M.D.,** and **O. J. Hayes, M.D.** Doctor Powers has just completed his residency training in obstetrics and gynecology at Louisville General Hospital. A graduate of the University of Louisville School of Medicine in 1955, he took his internship at St. Joseph Infirmary, Louisville, where he also took a year's training in general surgery.

Joseph M. Ray, M.D., recently joined the staff of the Lexington VA hospital. Doctor Ray, a graduate of the University of Louisville School of Medicine in 1925, was transferred from the VA Hospital Swananoa Division in North Carolina. He was formerly associated with the VA office and the VA hospital in Lexington. His past experience includes private practice in Hazard and as chief physician at the Columbus Mining Co., Hazard.

James G. Sills, M.D., is now in general practice in Hardinsburg. A 1959 graduate of the University of Louisville School of Medicine, he completed his internship at Springfield City Hospital, Springfield, Ohio, last spring.

Glenn R. Stoutt, Jr., M.D., a native of Chattanooga, Tenn., has started the practice of pediatrics in Louisville in association with **Richard Greathouse, M.D.** Doctor Stoutt received his medical degree from the University of Tennessee Medical School in 1954, interned at St. Joseph Hospital, Lexington, and took his residency training in the Department of Pediatrics, University of Louisville. Following duty in the U. S. Navy, he practiced in Evarts and Harlan for a short time before going to Louisville for his residency in pediatrics.

A. Myron Johnson, M.D., Wilmore, has been awarded a Wyeth Laboratories pediatric residency fellowship —a $4,800 grant that will enable him to spend two years at Children's Medical Center, Boston, in advanced study in the care and treatment of children. Doctor Johnson is a graduate of Vanderbilt University School of Medicine.

W. M. Savage, M.D., Maysville, a Fellow of the American College of Surgery since 1952, has been certified as a Diplomate of the American Board of Abdominal Surgery. Doctor Savage was recently renamed president of the Mason County Medical Society.

Molloy G. Veal, Jr., M.D., is now on the staff of the Henderson Clinic where he will limit his practice to internal medicine. A 1948 graduate of the University of Louisville School of Medicine, he interned and took his residency training at Brooke Army Hospital, Ft. Sam Houston, Texas. Following more than seven years as a major in the U. S. Army Medical Corps he was at the V. A. Hospital in Shreveport, La., for four years.

Urologists Plan Dinner Sept. 22

The Kentucky Urological Society is planning a dinner meeting on Thursday, September 22, as a climax to the Annual Meeting. A social hour will be held in Parlors A, B and C at the Brown Hotel, followed by a dinner at the Old House. The program will include entertainment and a scientific session. Reservations may be made with A. M. Isaacs, M.D., Francis Building, Louisville.

U. K. Doctor Gets $71,901 Grant

E. Douglas Rees, M.D., assistant professor of medicine at the University of Kentucky Medical Center, has received a $71,901 cancer-research award from the United States Public Health Service. The three-year grant will enable Doctor Rees to investigate the development of breast tumors and chemical changes in such tumors induced in albino rats.

Druggists to Hear Louisville M.D.

The Federal Wholesale Druggists' Association has invited Carroll L. Witten, M.D., Louisville, to address its 45th annual convention. The meeting is scheduled to be held in September at the Greenbrier Hotel, White Sulphur, W. Va.

Dr. Hambley In Mayor's Role

W. C. Hambley, M.D., has been acting as major of Pikeville since the resignation of Mayor Bill Pauley on July 27. He will perform the duties of that office until the Pikeville City Council selects a replacement to serve until the November election. Doctor Hambley was named mayor pro tem by his fellow council members in January.



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supply: Bottles of 25 and 100 tablets. Bonadoxin also effectively relieves nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, and motion sickness. Also useful in postoperative nausea and vomiting.

Bibliography on request.

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In Memoriam

OLIVER C. COOK, M.D.
Marion
1871 - 1960

Oliver C. Cook, M.D., of Marion, who retired three years ago after practicing in Crittenden county for 58 years, died July 30 at Crittenden County Hospital. He was 89 years old.

A native of Tennessee, Doctor Cook was graduated from the University of Tennessee Medical School in 1899.

ANDREW J. DAVIDSON, M.D.
Prestonsburg
1883 - 1960

Andrew Jackson Davidson, M.D., who was graduated from the University of Louisville School of Medicine in 1909, died of a heart attack at his home in Prestonsburg on July 17. He had practiced in Prestonsburg since 1932.

Doctor Davidson last year celebrated 50 years in the medical profession with an open house which was attended by about 250 friends. Before starting practice in Prestonsburg he practiced in Topeka, Kan., and Tampa, Fla.

MORTON FAULKNER, M.D.
Mt. Sterling
1879 - 1960

Morton Faulkner, a physician for 54 years in Powell and Montgomery counties, died on July 11 after a long illness. He had been in active practice up until about two years ago when he was forced to retire because of a stroke.

Doctor Faulkner, a 1904 graduate of the University of Louisville School of Medicine, was a native of Powell County. He observed his 50th anniversary as a practicing physician in 1954. At one time he served as Montgomery county health officer.

ARTHUR J. SCHWERTMAN, M.D.
Covington
1893 - 1960

Arthur J. Schwertman, M.D., died at St. Elizabeth Hospital, Covington, on July 23 after a brief illness. He had practiced in Covington for 35 years, was president of the staff of St. Elizabeth Hospital in 1935, and had served the hospital as a member and chief of the medical section until 1958.

A former chairman of the Southern Medical Association, Doctor Schwertman received his M.D. degree from the University of Cincinnati Medical School in 1925. He took his postgraduate training at Harvard, Columbia and Michigan Universities and the University of Vienna.

THOMAS E. MOSS, M.D.
Woodville
1877 - 1960

Thomas E. Moss, M.D., Woodville physician who had practiced in Western Kentucky for half a century, died July 26 at Western Baptist Hospital, Paducah. He had been ill for five years.

Doctor Moss practiced medicine in Louisiana and the Philippines before locating in Kentucky.

H. B. STEWART, M.D.
Morganfield
1873 - 1960

Herbert Burns Stewart, M.D., emeritus member of the KSMA, died July 31 at Our Lady of Mercy Hospital, Morganfield. He was 87.

Doctor Stewart, who practiced medicine in Union county for 54 years, had been located at Morganfield since 1917. He was a 1904 graduate of Kentucky University Medical Department.

CLARENCE H. ZURCHER, M.D.
Louisville
1906 - 1960

Clarence H. Zurcher, M.D., who practiced in Louisville from 1932 to 1950, died at Norton Memorial Infirmary on July 21. He had retired from active practice in 1950 because of ill health.

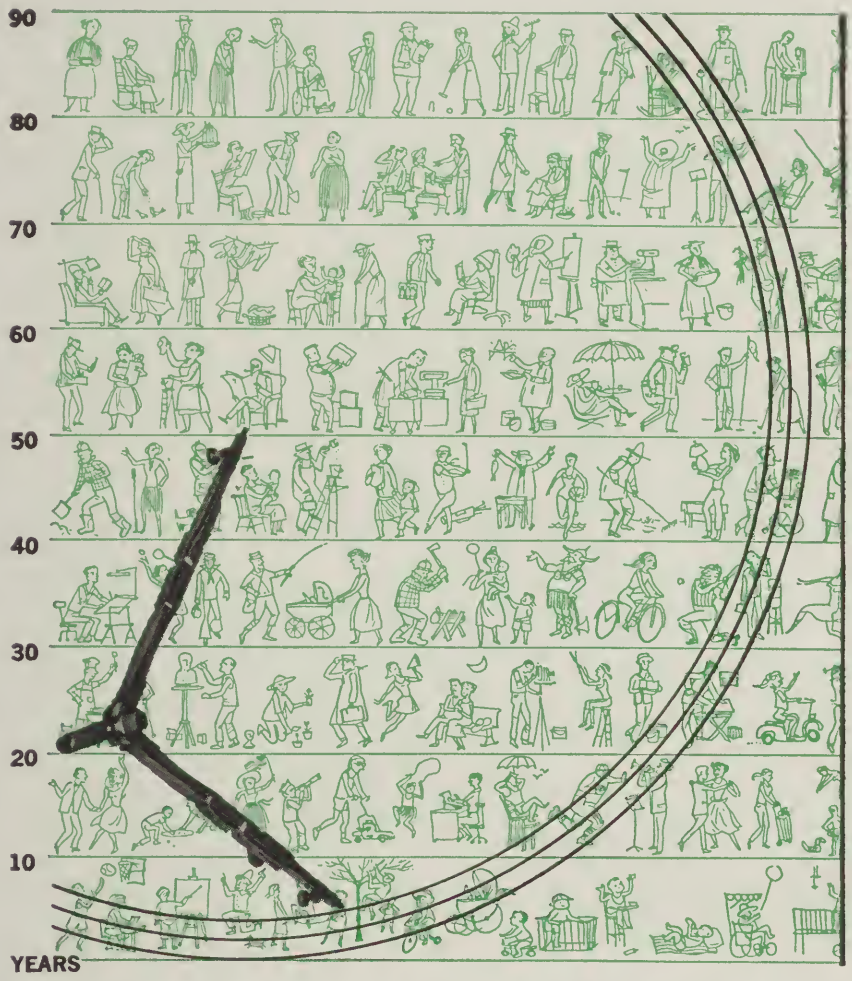
A native of Norwalk, Ohio, he was graduated from the University of Louisville Medical School in 1931. He did his premedical study at Heidelberg University, Tiffin, Ohio.

Ob-Gyn Nurses to Meet In Columbus

District V of the American College of Obstetricians and Gynecologists is sponsoring a two-day conference for maternity and gynecological nurses in Columbus, Ohio, November 3 and 4. Registered nurses affiliated with these services, from Ontario, Kentucky, Indiana, Ohio and Michigan, are eligible to attend.

The registration fee is $12.50, including two luncheons. Further information may be obtained by writing: Ob-Gyn Nurses' Conference, P. O. Box 95, Columbus 16, Ohio.

Carl Weber Watson, Lexington, holder of a National Medical Sloan Foundation scholarship for the study of medicine at the University of Kentucky, has been named the recipient of the seventh annual Whitehouse premedical award at the University of Kentucky. He was selected by the U. of K.'s predental and premedical recommendation committee on the basis of his industry, professional interest, integrity and personality. **A. J. Whitehouse, M.D.,** Lexington, gives the $100 award. One of the 10 holders of Sloan Foundation scholarships in the U. S., he will receive $1,500 per year toward his medical education. The scholarships were inaugurated this year to lessen the shortage of Negro physicians and surgeons. He will start his medical studies at U. of K. in September.



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Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules. Prescription only.

Complete bibliography available on request.

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(brand of dextromethorphan HBr) ..... 30 mg.
Terpin hydrate .....180 mg.
APAP (N-acetyl-p-aminophenol) .....325 mg.

References: 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

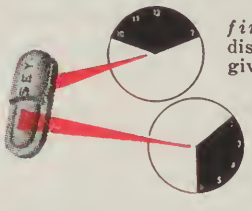
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Should You File A Declaration Of Estimated Tax?

EACH year a number of taxpayers are confronted with a statement from Uncle Sam showing a penalty due for failure to file a Declaration of Estimated tax. Even though your return has been properly filed—you have acted in good faith—this penalty can be asserted. Depending on your income tax bracket, this provision of the Internal Revenue Code can be quite costly in addition to the tax payment.

Who Must Estimate?

You should be filing a declaration of estimated tax if:

1. Taxable income from items other than wages is $100 or less and income subject to withholding is expected to exceed $5,000 in the case of a single person; or $10,000 for a married couple filing a joint return, head of household or surviving spouse.

or

2. Your gross income for a year is expected to include over $100 besides your wages on which tax is withheld and is expected to be more than the sum of (a) $600 for each exemption, plus (b) $400.

These are the legal requirements for filing a declaration. However, the penalty provisions are usually considerably more liberal, particularly if the income is subject to withholding and the return is filed in January. It should be noted here that the penalty provisions of this code section cannot be avoided by filing no estimates and then, prior to January 31, filing a tax return and paying all of the due tax in a lump sum payment. This is a misconception that has cost a number of taxpayers a penalty.

For the calendar-year taxpayer, there are four "estimation days"—April 15, June 15, September 15 and the following January 15. If the requirements for a declaration are met before April 1, the declaration must be filed by April 15. If the requirements are first met after April 1 but before June 2, the declaration is due June 15. If the requirements are met after June 1, but before September 2, the declaration is due September 15. If the requirements are first met after September 1, the declaration is due January 15, but a final return and payment in full, not later than January 31, will avoid the necessity for filing this last quarter declaration.

Note! If you should be filing an estimate and have not yet done so, you should file an estimate prior to September 15 in order to cut down on the running period for interest and penalities.

Penalty for Failure to File

Provided you have filed an estimate on the due dates, but you estimated your quarterly payments too low (the four quarterly payments being less than 70% of the total tax due on the final return) a penalty of 6% per annum, computed on the amount and duration, may be added to the final tax liability. This is based on the deficiency in quarterly payments. Assuming the requirement is met after June 1st, the penalty would run from September 15 until the return for the year is filed. If the estimated tax paid is 70% or more of the actual tax liability, no penalty is assessed.

It is often difficult for physicians and other self-employed persons who have unstable income to accurately estimate their tax liability within 70% of the actual tax liability. There are several procedures that can be used to avoid this penalty, such as amending your estimate. However, the simplest procedure is to base a coming year's estimate on the prior year's return. For example, assume you are filing an estimate for 1961. If you will base your income and tax liability for 1961 same as 1960—meaning your declaration of estimated tax will be identical to the actual tax liability for 1960—there will be no penalty even though the 1961 income runs higher than estimated. This is a procedure whereby you can avoid any penalty, assuming there is no change in tax rates from one year to the following. By this method you eliminate the need to constantly be revising your estimated tax payments.

These provisions were enacted into the Code in order that individuals receiving income not subject to withholding be put on the same basis as those having wages subject to withholding. In order to comply with the law and to avoid paying unnecessary penalties, it is recommended that you check closely into your status as an "estimator" if you are not already filing these declarations.

William E. Rudd



1,928 published cases in the two years since TAO was released for general use show:

94.3% effectiveness in respiratory infections (617 cases including tonsillitis, staphylococcal and streptococcal pharyngitis, bronchitis, infectious asthma, broncho-pneumonia, lobar pneumonia, bronchiectasis, lung abscess, otitis.) **You can count on TAO.**

92% effectiveness in skin and soft tissue infections (900 cases including pyoderma, impetigo, acne, infected skin disorders, wounds, incisions and burns, furunculosis, abscess, cellulitis, chronic ulcer, adenitis.) **You can count on TAO.**

87.1% effectiveness in genitourinary infections (349 cases including urethritis, cystitis, pyelitis, pyelonephritis, orchitis, pelvic inflammation, acute gonococcal urethritis, lymphogranuloma venereum.) **You can count on TAO.**

75.8% effectiveness in diverse infections (62 cases including fever of undetermined origin, peritoneal abscess, osteitis, periarthritis, septic arthritis, staphylococcal enterocolitis, gastroenteritis, carriers of staphylococci.) **You can count on TAO.**

95.6% of 1,928 cases free of side effects—in the remaining 4.4%, reactions were chiefly mild gastrointestinal disturbances which seldom necessitated discontinuance of therapy.

*In 884 of 1,928 cases the causative organisms were mostly staphylococci. The majority of clinical isolates were found to be resistant to at least one of the commonly used antibiotics and many patients had failed to respond to previous therapy with one or more antibiotics. **TAO proved 93.4% effective in these 884 cases.**

Complete bibliography available on request.

DOSAGE: varies according to severity of infection. Usual adult dose—250 to 500 mg. q.i.d. Usual pediatric dose: 3-5 mg./lb. body weight every 6 hours.

NOTE: In some children, when TAO was administered at considerably higher than therapeutic levels for extended periods, transient-jaundice and other indications of liver dysfunction have been noted. A rapid and complete return to normal occurred when TAO was withdrawn.

SUPPLY: TAO CAPSULES—250 mg. and 125 mg., bottles of 60. TAO ORAL SUSPENSION—125 mg. per 5 cc. when reconstituted, palatable cherry flavor, 60 cc. bottles. TAO PEDIATRIC DROPS—100 mg. per cc. when reconstituted, flavorful; special calibrated dropper, 10 cc. bottles. INTRAMUSCULAR or INTRAVENOUS—10 cc. vials, as oleandomycin phosphate.

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Each tablet contains: 1 mg. 9-aminoacridine undecylenate; 1 mg. N-myristyl-3-hydroxybutylamine hydrochloride; 1.8 mg. methylbenzethonium chloride; 12.5 mg. succinic acid; plus lactose and starch as excipients, in a rapidly disintegrating soluble vaginal tablet.

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IN THE BOOKS



ENCYCLOPEDIA OF MEDICAL SYNDROMES: by Robert H. Durham, M.D., F.A.C.P.; published by Paul B. Hoeber, Inc., Medical Division of Harper & Brothers, New York; 1960; 628 pages; price, $13.50.

This book contains an alphabetical listing of nearly 1,000 syndromes and their synonyms with a brief description of each. Etiological and pathological features of each syndrome are discussed concisely as are clinical manifestations, laboratory findings, treatment, complications and prognosis. At the end of each syndrome description the author gives at least one reference to a more detailed consideration of that syndrome which in turn will lead to additional reference material.

The syndromes are listed according to eponymic and descriptive titles and there are multiple listings for syndromes of multiple eponymic or descriptive designation. The index is complete with listings according to systems, general pathological states, specific organ disorders and infections.

A collection of syndromes such as this is unique in medical publication and its value is emphasized by the ever-increasing number of syndromes and the many names assigned thereto. Standard medical dictionaries offer brief and inadequate coverage of syndromes and textbooks often omit them in favor of well established disease entities. The author has prepared an orderly and well organized book that meets a definite need.

The general listing, indexing and cross indexing leaves little to be desired. The physician with a hazy memory and poor recollection in search of a syndrome vague in his mind will be led easily and quickly to an answer in this book. And the references offered will be of great value in pursuing the find in more detail.

The descriptive material is concise yet informative and easy to read. The coverage is wide and because of this the book should interest physicians in most all fields of clinical medicine. The volume should be a part of every good reference library.

John S. Llewellyn, M.D.

DRUGS OF CHOICE 1960-1961 (Second Edition): Walter Modell, M.D., editor; published by the C. V. Mosby Company, Inc., St. Louis; 1960; 958 pages; price, $13.50.

Drugs Of Choice may be regarded as a sort of cross index to Current Therapy. Like that work, it expresses the opinions of experts, based on their broad and deep experience, but it starts with pharmacologic classifications of drugs instead of with clinical problems to be treated. It is an encyclopedic volume of 42 chapters. It represents a vast labor of scholarship, and of love for ailing mankind.

The 47 contributors, 16 of whom are New Yorkers, are men of such experience as to give the book authority and lustre. They write tersely, and conform well to the book's purpose. Examples of chapter titles are: The Choice of a Diuretic
The Choice of an Antibacterial Agent
The Choice of an Anesthetic
The Choice of an Anticonvulsant
The Choice of Drugs for Diseases of the Heart
The Choice of Drugs for Urologic Disorders—
this contributed by Dr. Robert Lich of Louisville.

Each chapter is in such form as to lead to instructed choices. In some short, unenthusiastic chapters such as "The Choice of a Skeletal Muscle Relaxant" no real choice is offered, and in monographic chapters like "The Choice of Agents to Adjust and Maintain Internal Homeostasis" it is hard to find the choices among the facts. But the book is useful and successful; its method and orientation are sound.

The hundred-page Drug Index, identifying drugs by their synonyms, is convenient. This would have been a good place to print the structural formulas, conspicuously absent from the text. Much medical thinking is related to chemistry, and the structures of therapeutic agents are needed for organizing one's information. Dr. Tracy Putnam's fine chapter on anticonvulsant drugs recognizes this. Perhaps a future edition may use his method more extensively.

Dr. Modell's prefaces recognize both the urgency and the impossibility of the service attempted by the book. Four months have passed since publication, and already one can insert warnings and encouragements from one's own experience. Only a card file perpetually corrected by a staff of abstractors can keep up with the changes in Therapeutics. Something of the sort is growing, in our Poison Information Centers, and it may be that the references of the future will be subsidiaries of A. T. & T.

Austin Bloch, M.D.

HOPE DEFERRED: by Jeanette Seletz; published by Vantage Press, Inc., New York, 1960; 546 pages; price, $4.50.

If you would like to relive your medical school and hospital house staff days, let me recommend "Hope Deferred" by Jeanette Seletz. It is a satisfying story of a country boy going through medical school and hospital training with all the experiences, hardships and emotions that you remember so well from your traveling along the same road.

As the Dean said, "The study of medicine implies a mission beyond any other on earth, a mission for

(Continued on Page 1105)



Diagnostic Quandaries

Colitis? Gall Bladder Disease?
Chronic Appendicitis?
Rheumatoid Arthritis? Regional Enteritis?

A DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.[1]

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica*. In 15 of these subjects, nine stool specimens were required to establish the diagnosis.[2]

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.[3]

Now treatment with Glarubin provides a means of differential diagnosis in suspected cases of amebiasis. Glarubin, a crystalline glycoside obtained from the fruit of *Simarouba glauca*, is a safe, effective amebicide. It contains no arsenic, bismuth, or iodine. Its virtual freedom from toxicity makes it practical to treat suspected cases without undertaking difficult, and frequently undependable, stool analyses. Marked improvement following administration of Glarubin indicates pathologically significant amebic infection.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis.

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*U.S. Pat. No. 2,864,745

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #70 (1959)—This patient was a white, 39 year old, married gravida 7, para 6, whose expected date of delivery was August 13, 1959. Her past medical, surgical and obstetrical history was unknown. She was seen initially with this pregnancy in her third month, March 16, 1959. At this time she was having chills, nausea and vomiting. She was given Combiotic, Lipogantrisin and Phenaphen. The next day, March 17, 1959, she was admitted to the hospital in what appeared to be a coma. Physical findings and laboratory tests were said to suggest a diagnosis of a cerebral accident. The patient was hospitalized until March 25, when she was discharged, improved, to her home. No mention was made of the treatment in the hospital.

She was in her physician's office on April 9, 1959. She complained of a headache, which she had had most of the entire pregnancy, although it was now less severe. Her blood pressure was 125/80, pulse 116, hemoglobin 85 per cent, weight 155 lbs. The 17th of April the patient was admitted to a larger hospital in another city. She was seen and examined by the medical and neurological services and was diagnosed as having "subdural hemorrhage" due to a possible leaking intracranial aneurysm. It was recommended that she be delivered by cesarean section electively two weeks before the expected date. She seemed to improve for some time under absolute bed rest and sedation, but she was rehospitalized at the initial hospital June 2-12, 1959.

On June 27, she was returned to the hospital in a comatose state. Her blood pressure was 130/80, pulse 130. She was placed in an oxygen tent and given supportive measures, but failed to respond to any therapy and she expired at 9:45 a.m., June 27, 1959. A surgeon then did a postmortem cesarean section and a living premature male infant was delivered. The birth weight was not recorded. The infant was placed in an air lock, but failed to respond and died July 1, 1959, (the third day of life) of terminal pneumonia.

No autopsy was obtained. The cause of the maternal death on the certificate was cerebral accident due to chronic nephritis due to toxemia of pregnancy.

Comment

This death was classified by the Committee as an indirect, non-preventable obstetric death. The diagnosis of toxemia on the death certificate seemed unsupported since the patient's blood pressure was always within the normal range and there was never any mention of pedal edema or proteinuria. The Committee felt the neurological diagnosis was the most likely. We need to be reminded that neurological complications can and often do occur during pregnancy. Pedowitz and Perell reviewed 77 cases of ruptured intracranial aneurysms in pregnancy and added two of their own cases. Of this total, 32 were confirmed by angiography, craniotomy or postmortem examination. The remaining 47 presented signs and symptoms of spontaneous subarachnoid hemorrhage, probably resulting from ruptured intracerebral aneurysms.

There are two major problems associated with pregnancy and ruptured intracerebral aneurysms: correct diagnosis and method of delivery. As in this case, toxemia of pregnancy must be ruled out. Even though subarachnoid bleeding may be present with both conditions, the lumbar puncture remains one of the primary diagnostic procedures in differential diagnosis.

The obstetrical management of a person with a ruptured congenital intracerebral aneurysm is controversial since so few cases have been reported. Abdominal delivery near term seems preferable. Oxytocics should not be routinely administered postpartum because of the possible increase in blood pressure and added intracranial pressure.

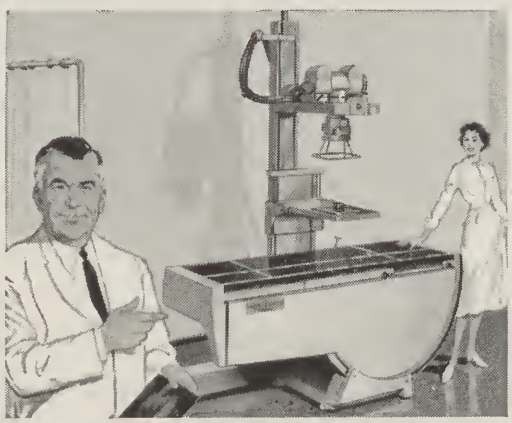
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PUBLIC HEALTH PAGE

Powermower Accidents—A Health Problem

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health, Commonwealth of Kentucky*

ONE punctured lung, 16 lost eyes, 103 lost fingers and 168 amputated toes . . . And . . . these figures represent only a portion of the accidents resulting from the use of powermowers in Kentucky during a three-year period just previous to July 1 of this year.

According to a survey made by the Division of Statistical Services of the Kentucky State Health Department, a total of 1,314 injuries due to powermower accidents were reported to have been treated by 317 physicians of Kentucky's 2,603 registered physicians in the three-year period. Of these, 389 were injuries resulting in permanent disability and 925 temporary. This is a high incidence of injury from accidents from such a cause.

In the survey, it was brought out that the foot, toe and finger, in that order, were the body areas most frequently injured in these accidents. There was, as noted earlier, permanent injury involving 103 fingers, 16 eyes, one lung, 78 feet and 168 toes. Also reported were 13 permanent leg injuries, two abdominal and six other permanent injuries in which the part of the body affected was not specified.

The figures obtained can be broken down in age groups according to the type of disability:

Under 13 years	148	total injuries
	26	permanent
	122	temporary
13—18 years	162	total injuries
	20	permanent
	142	temporary
19—45 years	662	total injuries
	215	permanent
	447	temporary
45 years and over	322	total injuries
	108	permanent
	214	temporary

Of the injuries in the age groups under 18, 20% were permanent, while 48% of those in the 19 to 45 group were permanent, and 50% in the 45 year and over group were permanent.

Letters were sent to all physicians in the state asking for their experience in treating powermower accidents. Of the 2,603 letters sent out on June 27, 693 cards were returned by July 11. This is a 26.6% return. Since a 20% return for a mail survey is considered excellent, we feel this response is enthusiastic. We are indeed most appreciative of the cooperation of the physicians.

Undoubtedly, many of the physicians who did not reply did treat powermower accidents. However, it is reasonable to assume that many more of those who did not send in a report saw no injuries from these accidents. Another factor to consider is that a number of physicians responding had not been practicing in Kentucky for the full three-year period. Thus, we cannot say with any certainty that our 26% sample response represents 26% of the powermower accidents occurring in the State of Kentucky in the three-year period. However, the large number of injuries reported does indicate that the use of powermowers is an accident problem.

Of the 693 physicians replying, 317 had treated patients with powermower injuries. Of the remaining 316 physicians, 48 specialized in a branch of medicine where they would not be apt to see such accidents, 12 stated they could not recall whether they had seen such injuries and the others had treated no patients with injuries resulting from powermower accidents.

In several cases, the injuries were a result of foreign objects such as rocks being hurled from the mower. In these cases, the injured person was not necessarily the operator. Bystanders, therefore, may make up an unknown part of the injured population in general. We have made no attempt to apply the statistical test of significance to these figures as we lack knowledge of the population exposed to risk.

In attempting to draw conclusions from the figures reported in this survey, we should keep in mind not only that we have no way of knowing how many were exposed to the hazards of powermowers but also that most of the data are a result of recall on the part of the physician and that the sample may not be representative of physician experience with powermower accidents in Kentucky.

The figure of accident incidence obtained is nonetheless worthy of thoughtful consideration—1,314 injuries from powermower accidents treated by 317 physicians in Kentucky during a three-year period—permanent disability to 389 persons.



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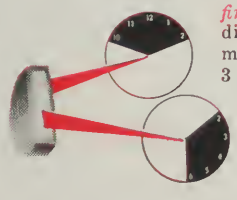
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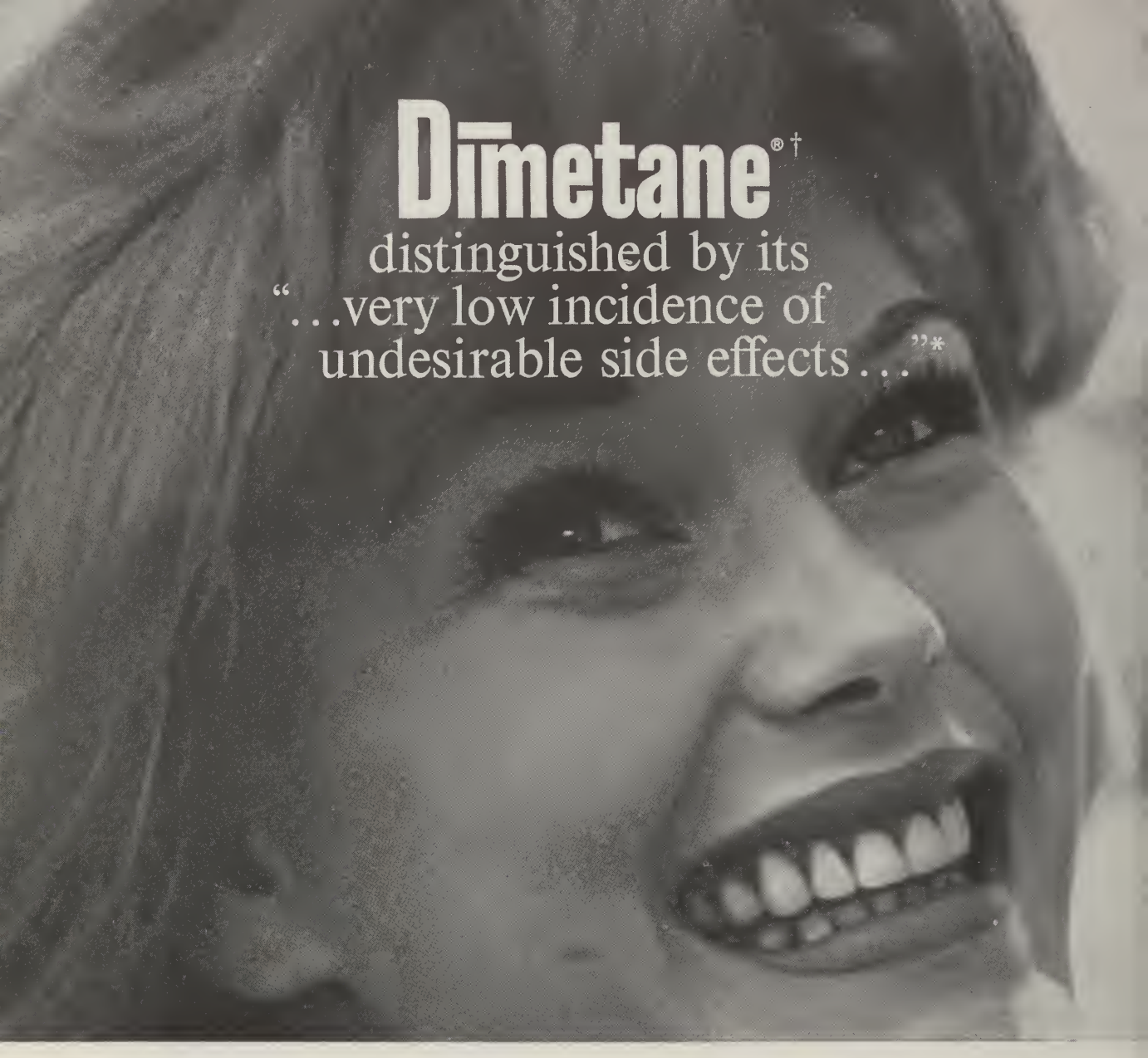
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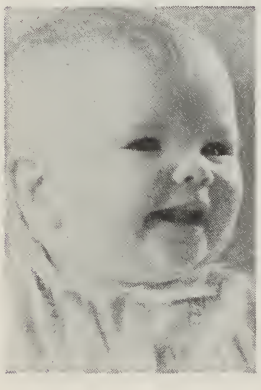
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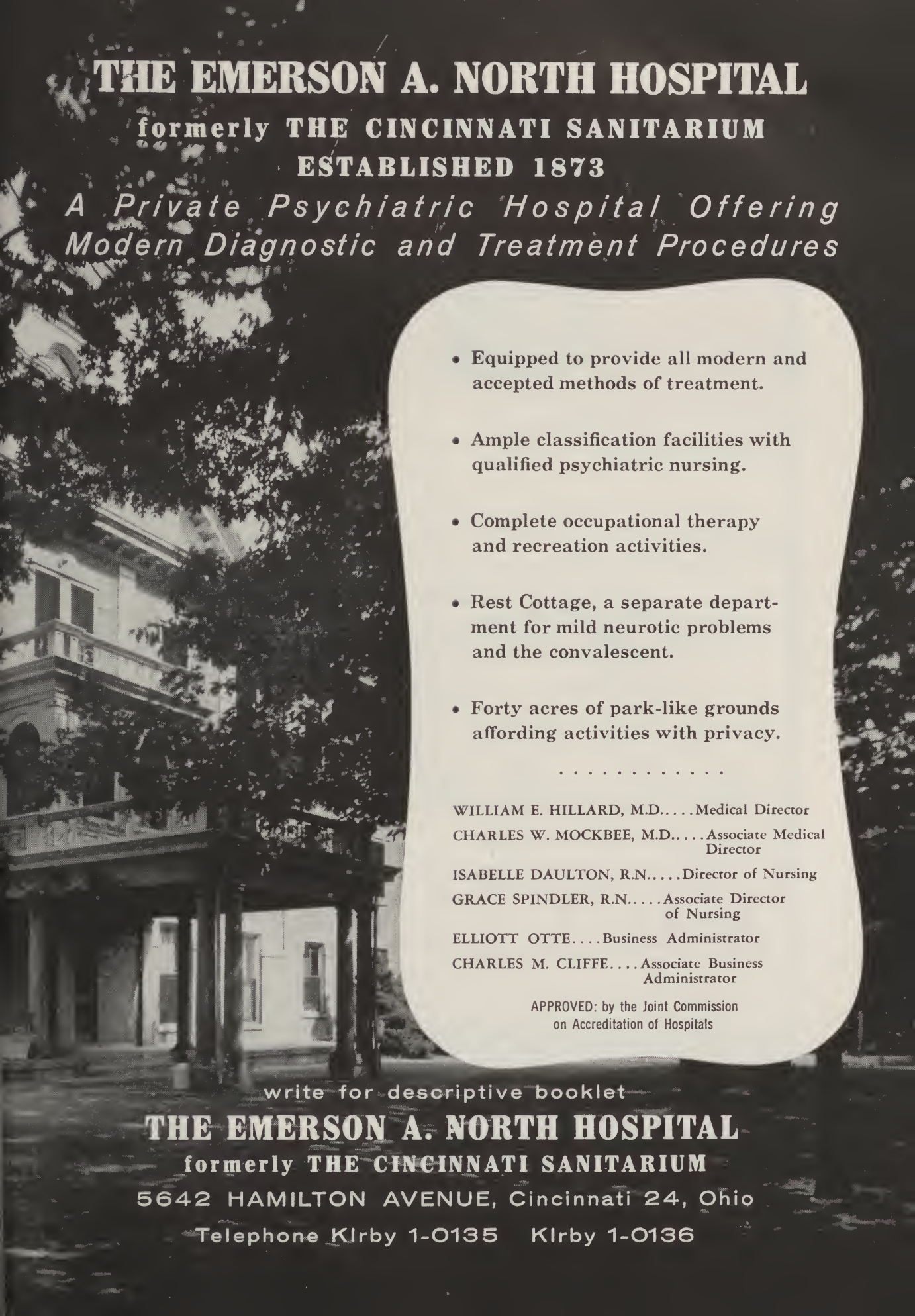
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*MC GOVERN, J. P., MC ELHENNEY, T. R., HALL, T. R., AND BURDON, K.D.: ANNALS OF ALLERGY 17:915, 1959.

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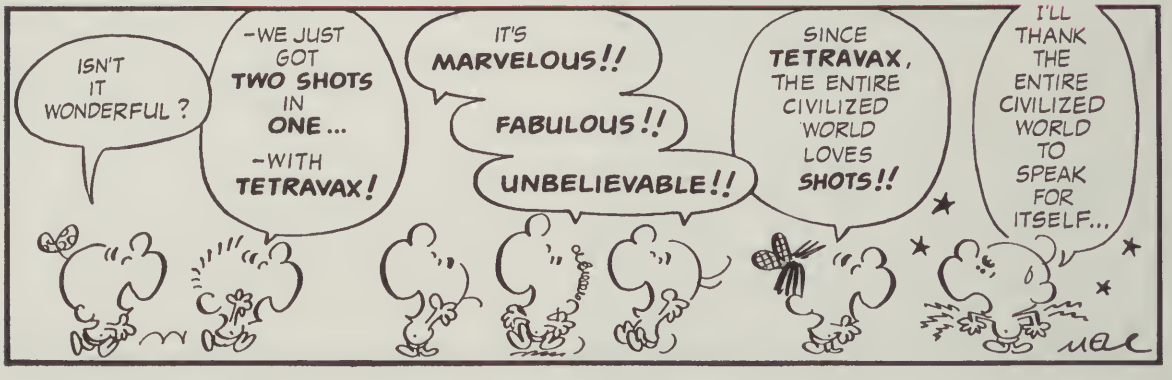
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IN THE BOOKS

(Continued from Page 1096)

men and women of open minds and unflagging devotion, for men and women of honor. You lose your soul to medicine and its service to humanity." The Dean reminds us that, For what shall it profit a man if he shall gain the whole world and lose his own soul.

"For, mark you, gentlemen, those who serve her truly, Medicine rarely repays in gold. She is a humble mistress and he who serves her shall go humbly shod. But him who serve her well she repays with a metal more precious than gold, with a treasure beyond compare: a great understanding, a might heart, a steady hand and a steadfast eye: A hand that will not tremble when those about him are palsied a, heart that will not flinch when others are afraid, resources that are endless when others are bankrupt, a peace that is indestructible though assailed by all the arrows of outrageous fortune for hope deferred maketh the heart sick; but when the desire cometh, it is a tree of life."

And again as the Dean said on Medical School graduation, "Forever, henceforth, my children, you speak but one language, the language of medicine, you serve but one mistress, the science of Healing: you have but one religion, the religion of Service: and you serve but one flag, the sign of Aescuoapius. I call God's blessing upon you in this, your hour of victory. Your heart, your mind may He ever guide, and your hand, so that you shall be a blessing to all mankind. Hail, my children and farewell."

May we Kentucky doctors rededicate our lives to Medicine and the good it does for the people of the world.

Hugh L. Houston, M.D.

Cancer Parley Set In Missouri

The American Cancer Society, Missouri Division, has announced Sunday, October 2, as the date for the 1960 Southeast Missouri Cancer Conference at the Colonial Tavern Restaurant, Cape Girardeau, Mo. Subjects assigned to the four guest speakers are: "Evaluation of Papanicolan Smear As Office Procedure," "Leukemias," "Early Diagnosis of Lump in Breast," and "Skin Malignancy." The annual conference is attended by physicians from Western Kentucky, Southern Illinois, Northwestern Tennessee, Northern Arkansas and Southeastern Missouri.

Military Surgeons Meet Oct. 30

"The Military Role in Medical Progress" will be the theme of the 67th Annual Convention of the Association of Military Surgeons set for October 30-November 2 in Washington, D. C. More than 2,000 American and International physicians, dentists, veterinarians, nurses and medical specialist delegates are expected to attend.

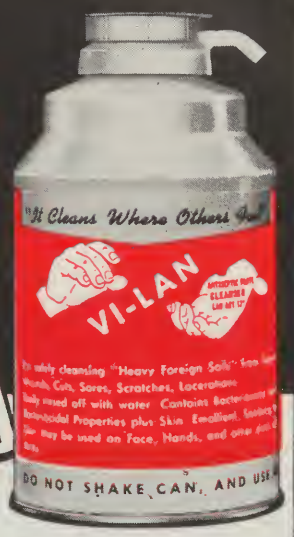
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INDICATIONS

HEAD: temporomandibular muscle spasm • NECK: acute torticollis, osteoarthritis of cervical spine with spasm of cervical muscles, whiplash injury • TRUNK AND CHEST: costochondritis, intercostal myositis, xiphodynia • BACK: acute and chronic lumbar strains and sprains, acute low back pain (unspecified), acute lumbar arthritis and traumatic injury, compression fracture, herniated intervertebral disc, post-disc syndrome, strained muscle(s) • EXTREMITIES: acute hip injury with muscle spasm, ankle sprain, arthritis (as of foot or knee), blow to shin followed by muscle spasm, bursitis, spasm or strain of muscle or muscle group, old fracture with recurrent spasm, Pellegrini-Stieda disease, tenosynovitis with associated pain and spasm.

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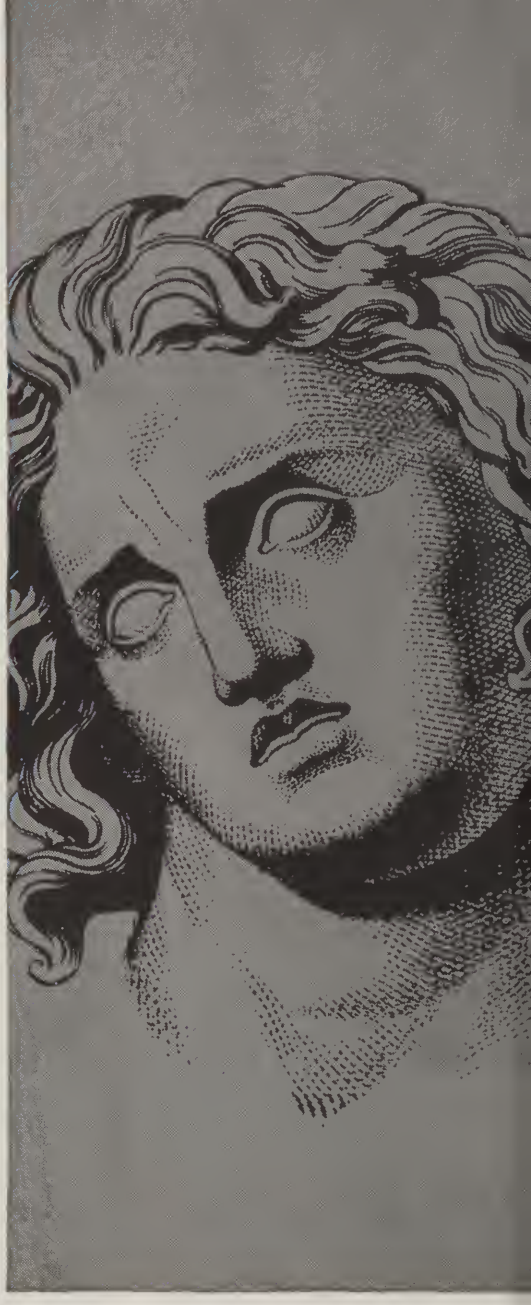
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References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Managraphs on Therapy 5:60 (Feb.) 1960. 2. Friend, D. H.; Clin. Pharm. & Therap. 1:5 (Mar.-Apr.) 1960. 3. Fard, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

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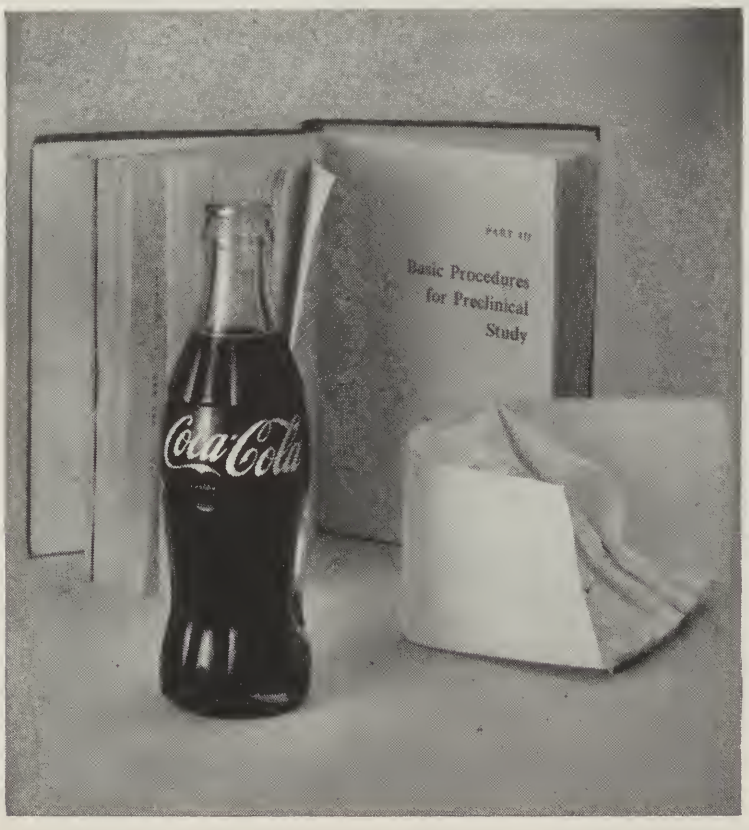
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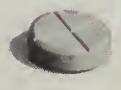
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1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: *Antibiotic Med. & Clin. Ther.* 3:378 (Nov.) 1956. 2. Boger, W. P.: In: *Antibiotics Annual* 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: *Antibiotic Med. & Clin. Ther.* 5:604 (Oct.) 1958. 4. Anderson, P. C., and Wissinger, H. A.: *U. S. Armed Forces M. J.* 10:1051 (Sept.) 1959.

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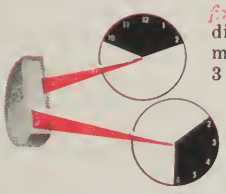
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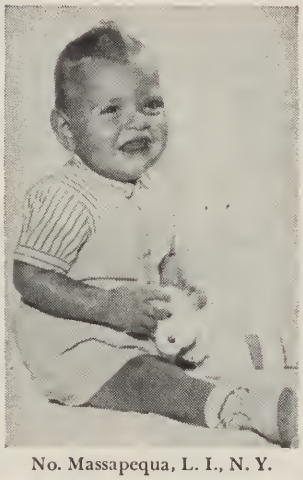
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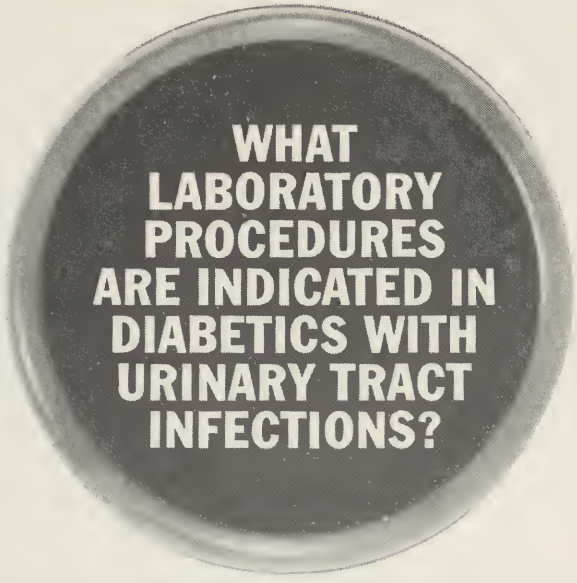
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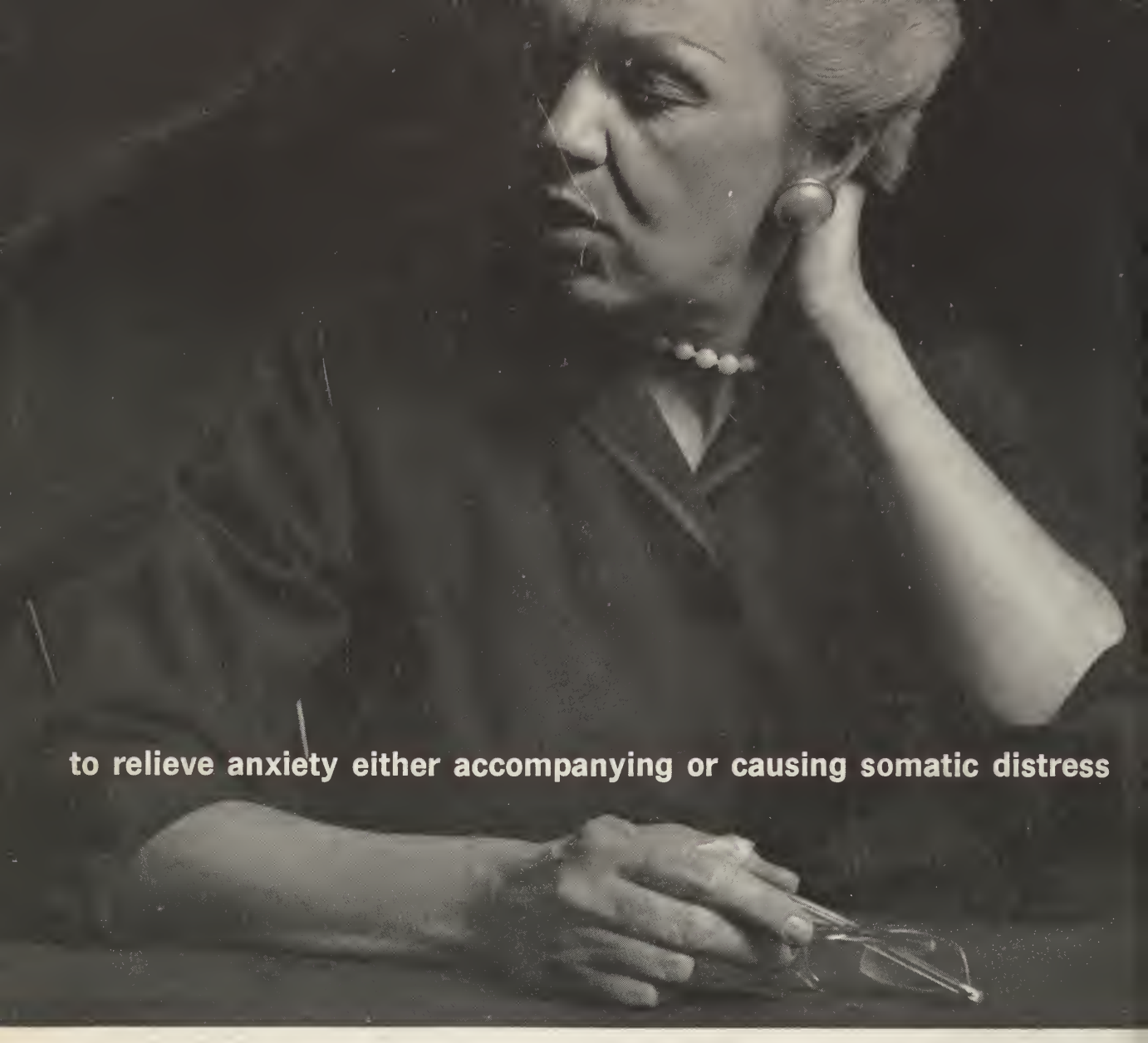
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1. Marx, F.J., in *Trifluoperazine: Further Clinical and Laboratory Studies,* Philadelphia, Lea & Febiger, 1959, p. 89.
2. Winkelman, N.W., Jr.: *ibid.,* p. 78.

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(1) Abraham, W., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, p. 132. (2) Crawley, J. W.: M. Clin. North America 42:317 *(March) 1958. (3) Bray, P. F.:* Pediatrics 23:151, *1959.*

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References: 1. Steigmann, F., **et al.:** Am. J. Gastroenterol. **33**:109 (Jan.) 1960. 2. Hock, C. W.: to be published. 3. Leming, B. H., Jr.: Clin. Med. **6**:423 (Mar.) 1959. 4. Data in Roerig Medical Department Files.

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MESSAGE FROM THE PRESIDENT

THE party conventions have faded from the television screens, the party platforms have been laid down, and the presidential candidates are scouring the country from Alaska to Florida and from Hawaii to Maine in the search of uncommitted votes. This is the year the people of the United States of America elect a President. At the same time they will vote for one-third of the members of the Senate, the entire membership of the House of Representatives, and innumerable state and local officers. Their men will meet the grave national and international problems which will face the nation in the next four years. Health problems must be met and solved also.

The Congress in approving the amended Mills Bill for the health care of the aging has opened the door for further expansion in the area of government medicine. This bill is the opening wedge and we can expect a strong effort to increase the coverage in the next session of Congress. If we are to keep the practice of medicine near its present form and change with the times by evolution, not revolution, we must vote and work for the men and the party that we feel will best support our views and position.

The medical profession is not large enough to form a pressure group, but we can make ourselves felt as individual citizens of influence beyond that of the ordinary person. We must inform ourselves about our side of the health problem and explain it to our patients and friends at every opportunity. We have suffered in silence too long and have allowed our opponents to make all the noise.

We must be sure that we are registered and vote and that every eligible member of our family and our employees vote. We must urge our patients to do the same. In the past many physicians have considered that it was better for their practice if they were silent on candidates and issues. That time is past. They should openly identify themselves with the party of their choice and should make an investment in democracy by contributing liberally in a financial way to it.

It is time that the practicing physician became a practicing citizen.

Richard E. Elliott



To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

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Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

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†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

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THE INSURANCE PAGE



Blue Shield – Whose Plan?

A KENTUCKY PHYSICIAN who is engaged in general practice was recently quoted as saying that there was no reason why general practitioners and internists should support the Kentucky Blue Shield Plan "since the plan is designed to help only surgeons and obstetricians."

If such a misconception of the role of Blue Shield exists in the mind of anyone, we earnestly suggest that he consider the following statements:

In 1959, Kentucky Physicians Mutual paid more than five million dollars to physicians; $2,484,297, or slightly less than half of this amount, was paid out for in-hospital surgical services.

GP's Benefit

For home or office surgery, a total of $271,175 was paid, much of which went to general practitioners since there is nowhere any stipulation that the physician rendering a service shall be a full-time surgeon or obstetrician.

During the same period, the obstetrical benefits paid out amounted to $738,699. Here, again, a large part of the services was rendered by general practitioners.

For anesthesia services, $575,220 (or 11.4%) of the total Blue Shield payments was paid to physicians, many of whom are in general practice.

For in-hospital medical care, Kentucky Physicians Mutual paid $685,395 or 13.6% of the total. Most of the Blue Shield members now have added the inexpensive medical rider to their basic plan, thus providing for payments to their internists or family doctors for in-hospital medical care.

For x-ray services, $258,698 (not including what was allowed on radio-isotopes) was paid in 1959.

These figures show that Blue Shield allowances are made to physicians in many areas of medicine.

A basic economic fact, too, is that if a patient has protection for a large portion of his doctors' bills, he is then in better position to pay for those bills (usually the smaller ones) which his prepayment does not cover, and for which he has not been paying dues or premiums.

30-Member Board

The governing board of our Blue Shield has 30 members, 25 of whom are physicians, selected from among the various specialties, including the general practice group. These men determine the policies of the organization. They are always sensitive to the needs and wishes of the other physicians of the State.

Only with Blue Shield does the medical profession have this control and representation.

Finally, it must be recognized that our Blue Shield plan was started by and is sponsored by the Kentucky State Medical Association in order to help the *public* (especially those of modest income and resources) provide necessary health care for themselves through the prepayment mechanisms.

Without Blue Shield and other voluntary prepayment plans, we would long ago have had governmental control of health care forced upon us.

For this reason, if for no other, *every* physician should support his Blue Shield plan.

W. Vinson Pierce, M. D.

Arterial representation adapted from Recueil de Planches, Tome Second, Chez Pellet a Geneve, 1779.



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REFERENCES: 1. Ford, R. V., and Nickell, J.: Ant. Med. & Clin. Ther. 6:461, 1959. 2. Fuchs, M., and Mallin, S. R.: Int. Rec. Med. 172:438, 1959. 3. Ford, R. V.: Int. Rec. Med. 172:434, 1959.

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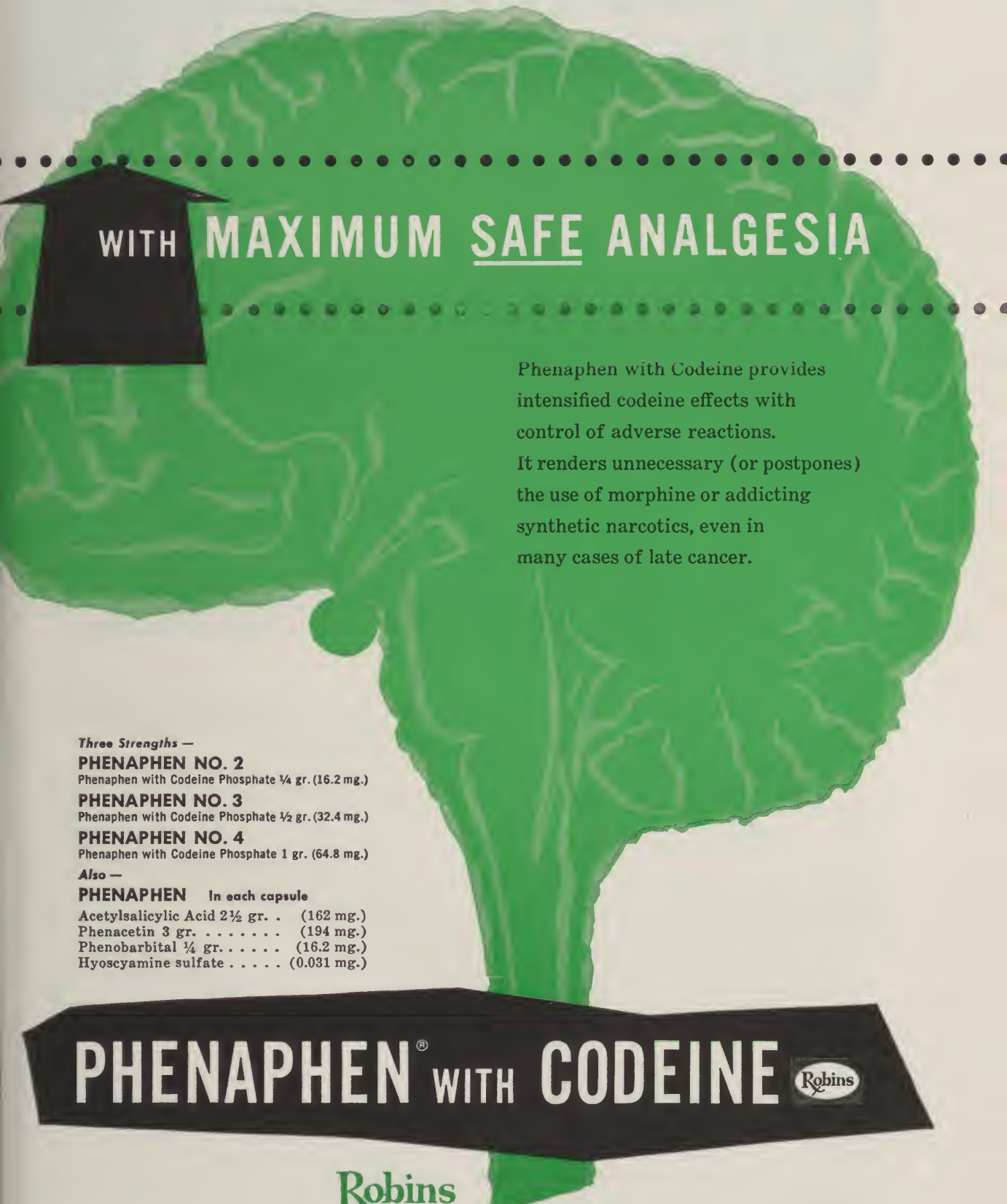
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WASHINGTON NEWS DIGEST

Washington, D. C.,—The Federal Government is offering states liberal matching funds to provide health care for needy and near-needy persons 65 years of age and older.

The program, which Congress approved in the bob-tailed post-convention session, is supported by the American Medical Association and allied health groups.

Congressional approval of the federal-state program marked a victory for the medical profession and a defeat for Democratic Presidential Nominee John F. Kennedy, the AFL-CIO and other advocates of the Social Security approach to the problem.

In a key vote issue, the Senate rejected by a 51-44 vote a Kennedy proposal that would have provided hospitalization and medical care for the aged under the Social Security system. The Kennedy plan would have required an increase in payroll taxes.

Republicans and Southern Democrats joined in the Senate to defeat the Social Security approach which was opposed vigorously by the medical profession.

Modified Verson

After voting down the Kennedy plan and a separate proposal of the Eisenhower Administration, the Senate passed a modified version of a House-approved program. The modifications, sponsored by Sen. Robert S. Kerr (D., Okla.) and others, provided for increases in the percentage of federal matching funds and for administrative changes designed to facilitate state participation.

Under the legislation as signed into law by President Eisenhower, (1) substantial increases are authorized in federal grants to states to help with health care expenses of the 2.4 million persons on old age assistance rolls, and (2) federal matching funds are offered the states to finance a new program of health care for an estimated 10 million aged persons who are not on relief but whose incomes may be inadequate to take care of all their health costs.

Start of the program was authorized for October 1 for those states where new state legislation is not required.

Participation Up to States

Administration of the program rests entirely with the states, subject to federal approval in broad terms. It is up to each individual state whether it participates. Eligibility standards for beneficiaries and what health care services are provided are matters for the states to decide.

If a state so chooses, it can take care of all the health needs of an eligible beneficiary. The law authorized inpatient hospital services; skilled nursing homes services; physicians' services; outpatient or clinic services; home care services; private duty nursing services; physical therapy and related services; dental services; laboratory and x-ray services; prescribed drugs, eyeglasses, dentures and prosthetic devices; diagnostic screening and preventive services, and any other medical care or remedial care recognized under state law.

For medical expenses of persons on old age assistance rolls, the Federal Government will contribute 50 to 80 per cent—with states with low per capita income getting the larger percentages of federal aid—of an amount equal to $12 multiplied by the number of old age assistance recipients in a particular state.

The matching formula will be the same for financing the health care of the near-needy but there is no $12 limitation figure.

Health, Education and Welfare officials estimated first-year costs of the program at $262 million—$202 million federal and $60 million state. Annual costs are estimated to rise by the end of the fifth year to $340 million federal and $180 million state. However, these estimates admittedly are no more than educated guesstimates because so much depends upon state action.

Kentucky's Breakdown

It was estimated that maximum participation and a state contribution of $576,000 would bring Kentucky $2.8 million in federal matching funds in the first year of the program.

The medical-care-for-aged legislation was included in an omnibus measure titled Social Security Amendments of 1960. It also eliminated the age 50 requirement for eligibility for disability insurance benefits.

The Senate knocked out of the House bill a provision that would have brought physicians under Social Security coverage.

On other legislation of interest to the medical profession:

Congress passed bills authorizing expenditure of $10 million of counter-part funds abroad to stimulate international research; authorizing up to 15 per cent of National Institutes of Health research grants for non-governmental medical research; directing a broad study of air pollution problems; requiring informative labeling on packages of hazardous substances for household use, and giving the government power to establish a tolerance on the amount of color additives that may be used in various products.

The Senate failed to act upon House-approved legislation that would have given physicians and other self-employed persons a tax break on income put into private pension plans.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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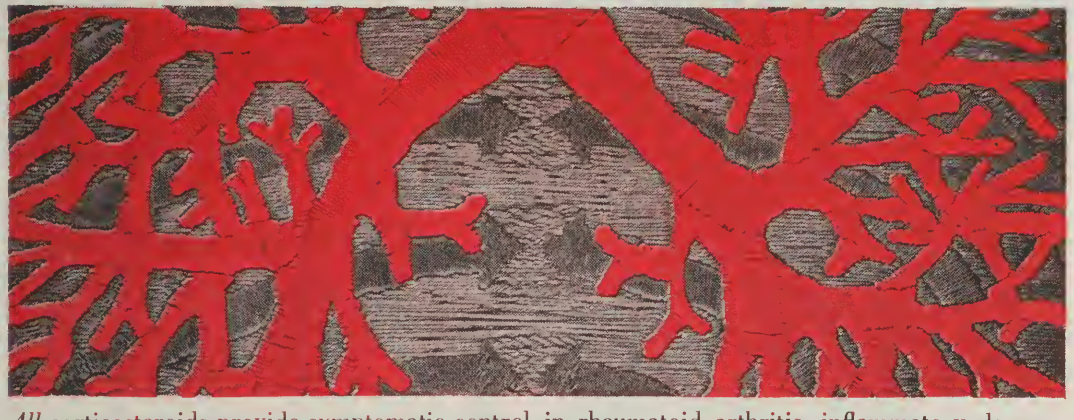
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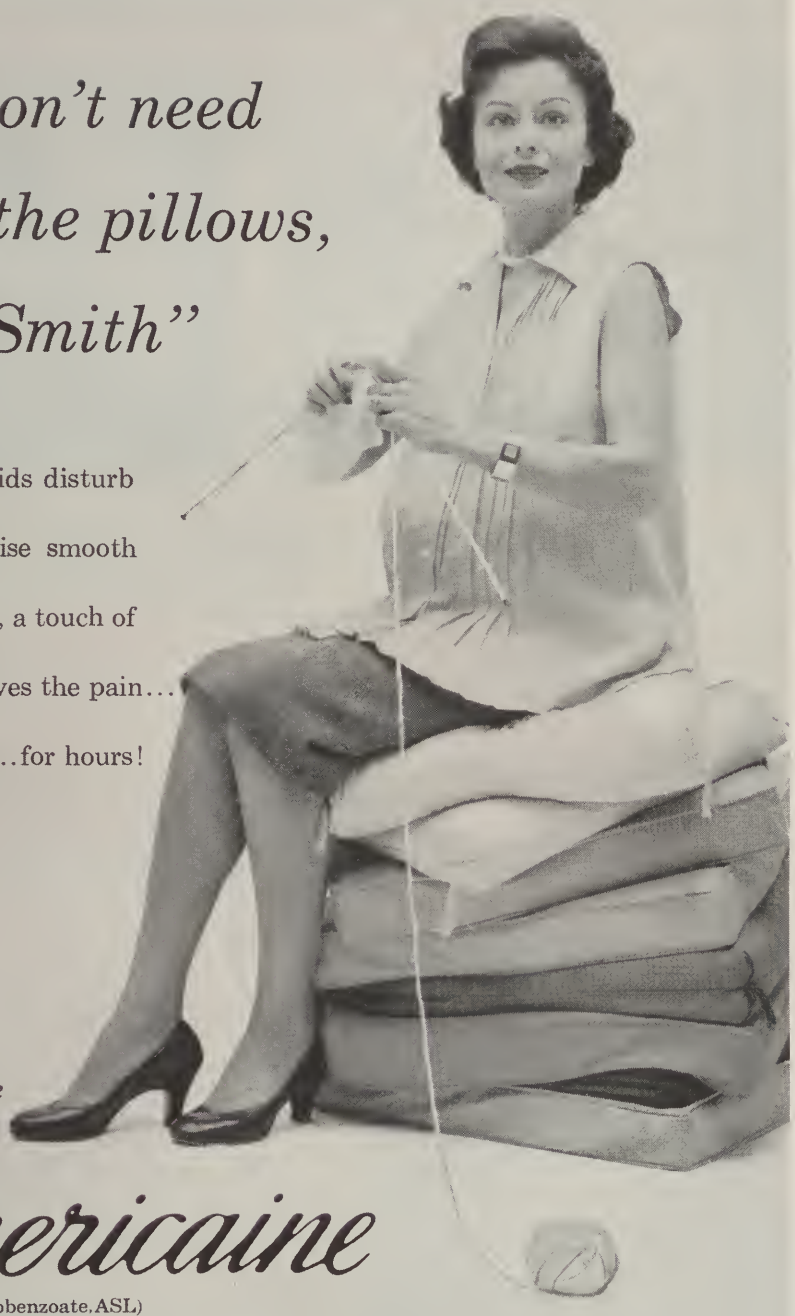
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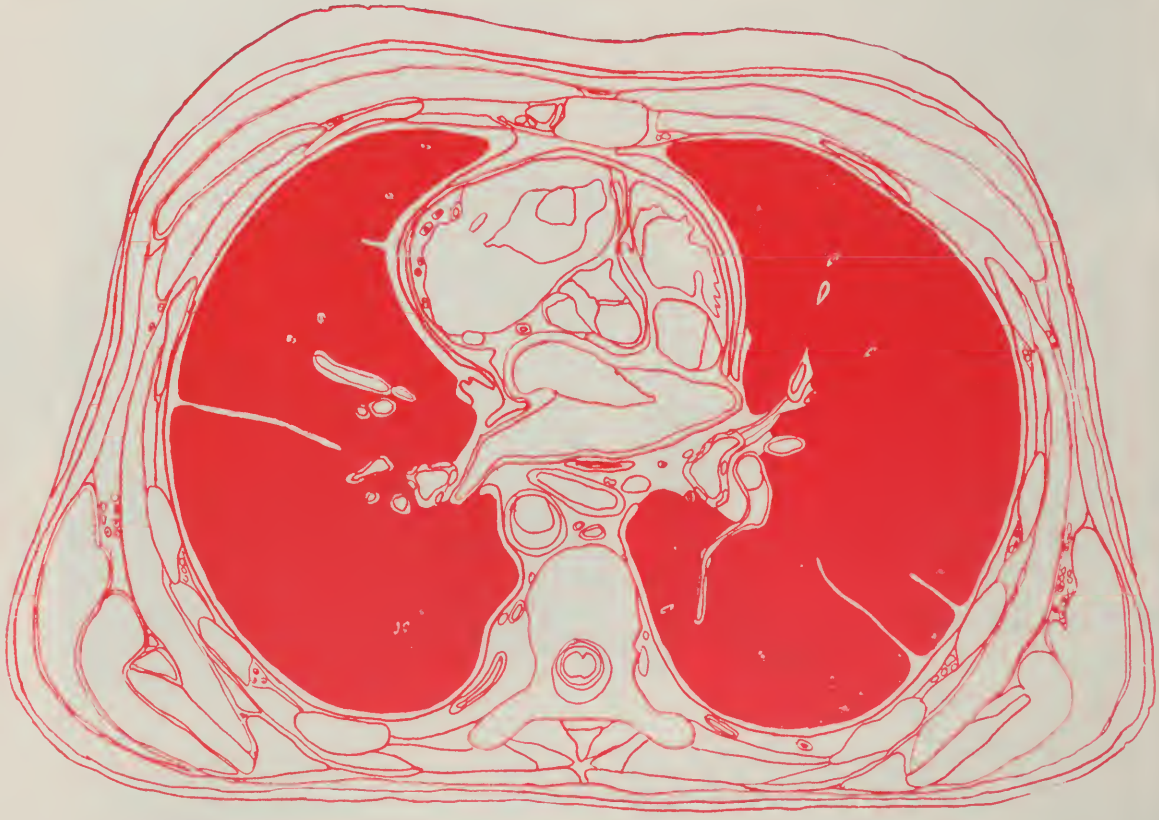
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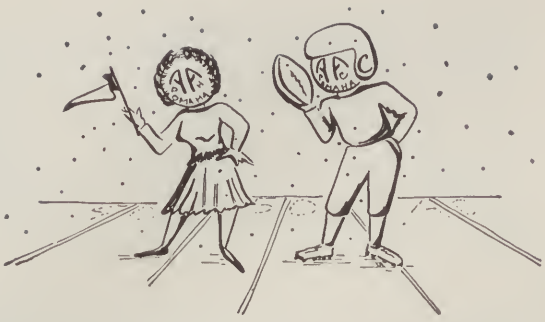
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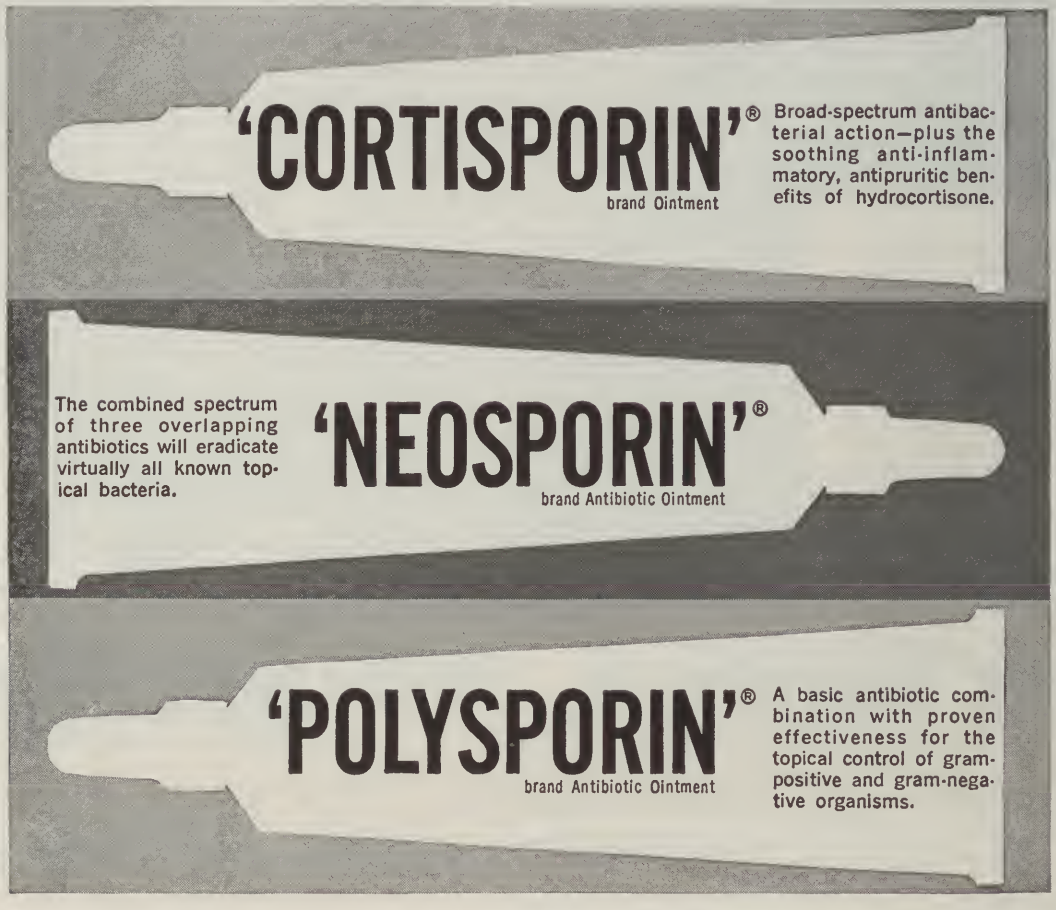
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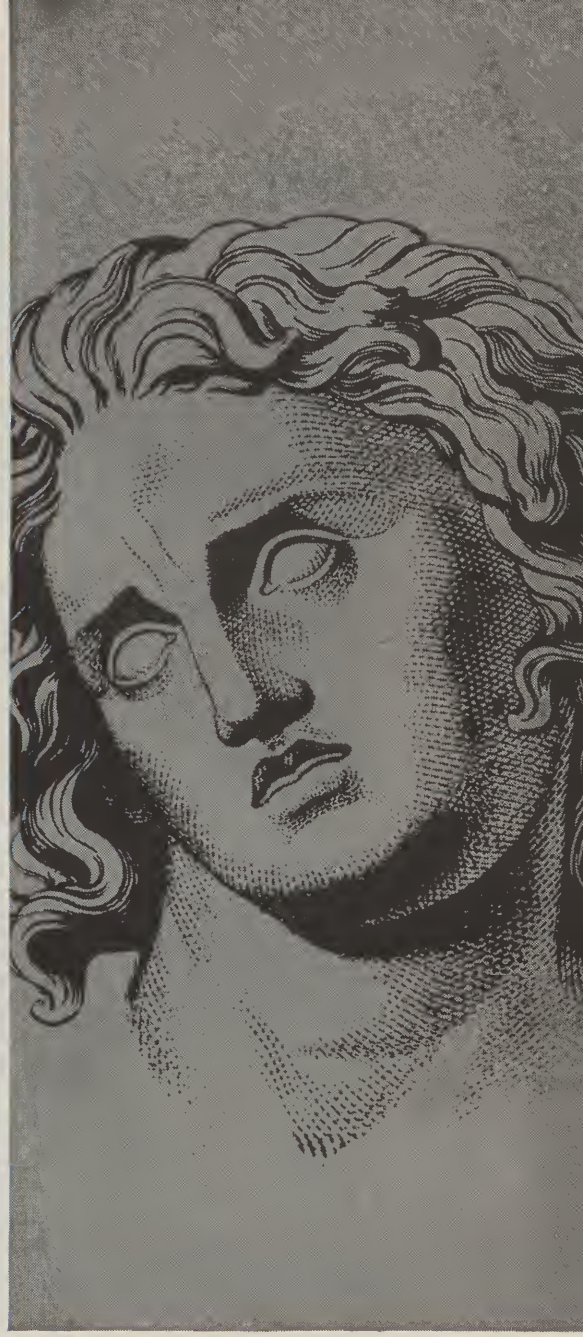
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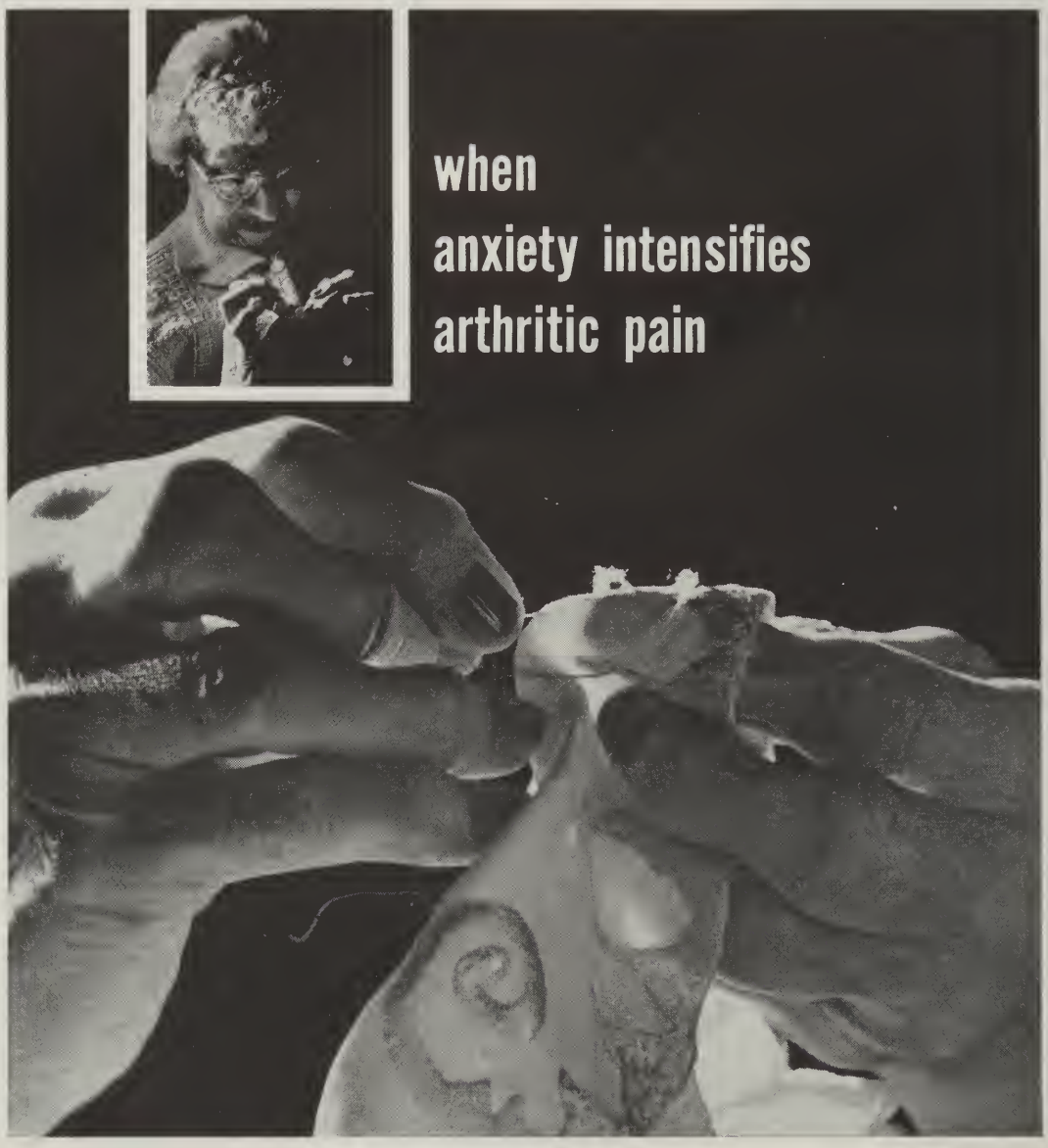
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VOL. 58 OCTOBER, 1960 NO. 10

Symposium on Gastroenterology

Differential Diagnosis Of Abdominal Pain —Medical Aspects

DAVID H. JOHNSTON, M.D.*

Lexington, Ky.

ABDOMINAL PAIN is one of the commonest complaints for which a physician is consulted, and one which frequently necessitates urgent treatment. It is almost always a manifestation of disease of the gastrointestinal or genitourinary tracts for which investigative techniques are highly developed, refined, and are readily available.

The Journal of KSMA presents its third annual Scientific Symposium, with Edmund D. Pellegrino, M.D., Lexington, as Special Symposium Editor. Doctor Pellegrino is professor and chairman of the Department of Medicine, University of Kentucky College of Medicine.

With the development in recent years of the fiberscope (a completely flexible endoscopic instrument designed to enable one to visualize all areas of the esophageal, gastric, and duodenal mucosa) and the multi-purpose, blind, intestinal biopsy tube, there is hardly an inch of the gastrointestinal tract that cannot be either visualized directly or biopsied. Moreover, abdominal pain is usually a symptom of diseases for which medical and surgical treatment may be very effective.

*Lexington Clinic, Lexington, Kentucky

For this reason alone it behooves every physician to become highly skilled and adept in the diagnosis and treatment of painful abdominal disease. Thus, a physician should approach the problem of abdominal pain with enthusiasm and the knowledge that treatment will usually give relief.

Physiology Of Abdominal Pain

The sensory innervation of the abdominal organs is complex. For purposes of our discussion, it is sufficient to point out that painful stimuli from the abdominal organs are transmitted to the central nervous system via two separate pathways. (Figure 1.) Nerve impulses of visceral pain are transmitted by way of the visceral afferent fibers with nerve endings in the substance of the abdominal organs coursing without interruption through the sympathetic chain, and into the spinal cord by way of the dorsal root ganglia.

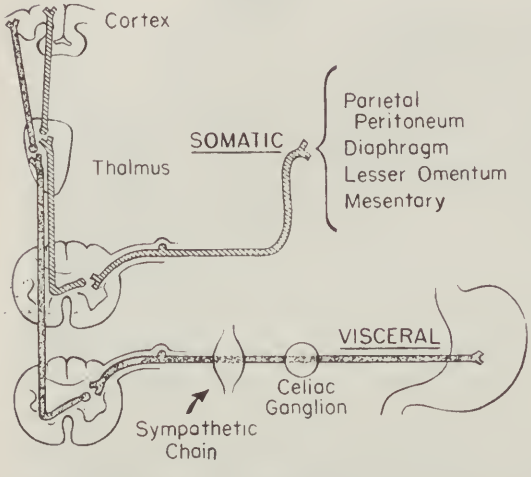
The first synapse occurs in the posterior horn; from here the pain stimulus travels by way of the contra-lateral spinothalamic tract to the thalmus and thence to the sensory cortex. Nerve impulses of somatic pain arise from multiple sensory pain endings in the parietal peri-

toneum, the body wall, the diaphragm, the mesentery, and the lesser omentum, and are transmitted over the lower thoracic and upper lumbar spinal nerves through the dorsal root ganglia and into the posterior horn. From here, the somatic pain stimulus travels to the brain in the same pathway as the nerve impulses of visceral pain.

A disease process may involve the sensitive pain receptors of both nerve pathways and be perceived in the brain as two different varieties of pain. Thus, there may be two components to any abdominal pain, namely a visceral component and a somatic component.

This concept is of the greatest importance

Figure 1



in the evaluation of abdominal pain. For example, the pain of acute appendicitis in the early phase is manifested clinically as a visceral pain of moderate intensity referred to the midline of the abdomen, in the epigastrium or periumbilical area. Later, as the inflammatory process involves the peritoneal covering of the appendix, the disease is manifested as a more intense, right lower quadrant pain with tenderness and involuntary muscle spasm. The pain of acute cholelithiasis is usually present in the midline of the epigastrium and is moderately severe whereas the pain of acute cholecystitis with an inflammatory reaction involving the peritoneal covering of the gallbladder is more severe and more accurately localized over the gallbladder in the right upper quadrant.

Moreover, the pain patterns in peptic ulcer may clearly indicate whether the lesion is limited to the involved viscus or whether penetration or invasion of adjacent tissue has occurred. In this way medical or surgical management may be, in part, anticipated. An unusual location or radiation of pain from the peptic ulcer is usually due to direct involvement of somatic nerve endings on the serosal surface of the duodenum or stomach. However, it must be remembered that visceral pain may also be referred to areas distant from its site of origin, and such occurrences have been explained by the so-called "over-flow mechanism." The close anatomical relationship of visceral and somatic fibers, with synapse in the posterior horn of the spinal cord is necessary to make such an hypothesis logical. For illustration, impulses of visceral pain of great intensity from an uncomplicated ulcer can over-flow into adjacent somatic neurons in the posterior horn and be perceived in the brain not only as visceral pain in the anterior abdomen but also as referred visceral pain in the chest or back.

Visceral Pain Often Vague

The characteristics and qualities of visceral and somatic pain are familiar to all clinicians. Visceral pain is often vague and ill-defined; it is usually poorly localized; and, for the most part, it is referred to the midline of the abdomen. Visceral pain is usually the result of distention or spasm of a hollow viscus or traction upon its mesentery. Visceral pain from a solid abdominal organ usually is the result of enlargement or distention of the organ, and the degree of tenderness and pain is related to the rapidity with which the enlargement or distention occurs.

Somatic Pain Well Defined

Chemical, mechanical, thermal and electrical stimuli applied to the visceral afferent fibers in the abdominal organs usually do not give rise to this type of pain. For example, biopsy of the esophageal mucosa, gastric mucosa and sigmoid mucosa, regardless of the presence of inflammation, is painless. In contrast to visceral pain somatic pain is well defined and accurately localized, is induced by the usual chemical, mechanical, thermal and electrical stimuli and is generally a more severe pain.

Although visceral pain is in general referred to the midline of the abdomen, there are a number of exceptions. Visceral pain from the ascending colon and hepatic flexure is commonly referred to the right upper quadrant or the

right median quadrant of the abdomen. Similarly, visceral pain from the transverse colon and splenic flexure is usually referred to the upper abdomen and left upper quadrant. Visceral pain from the descending and sigmoid colon is, of course, referred to the left lower quadrant and visceral pain from the ureters and kidneys is lateralized.

Through a variety of entero-enteric reflexes painful abdominal disease may be accompanied by a number of functional disturbances whose manifestations may be far removed from the site of the disease process. Examples of such disturbances are the diarrhea that occasionally accompanies a coronary occlusion or an acute cholelithiasis, and the irritable colon syndrome which frequently accompanies peptic ulcer disease.

Clinical Evaluation and Diagnosis

A careful history is still the most reliable method of arriving at the correct diagnosis of abdominal pain. It should be obtained by indirect questioning and whenever possible by allowing the patient to tell his story in chronological order without interruption. The questioning should be made in a language which the patient understands, and to do this properly the physician must be familiar with the various idiomatic expressions and terms used by different economic and ethnic groups in his community or surrounding areas. Naturally, historical data from patients who are dull, expressionless and reticent is much less reliable because the specific details must be obtained by direct questioning. Such patients are frequently very suggestible and may answer yes or no indiscriminately.

It cannot be stated too strongly that the more time a physician spends in taking a careful history the less time and expense he will find necessary to arrive at a correct diagnosis. An adequate past history, family history, marital history and social history are necessary to uncover any genetic, environmental, or emotional factors that may be playing a part in the production of symptoms. Equally important is the review of systems which will point to other body systems that may be involved simultaneously or that may be aggravating the abdominal disease, or that may be the primary seat of disease of which the abdominal pain is only the distant manifestation.

The review of systems may also reveal the presence of vague or bizarre symptoms in multiple organ systems. This frequently turns out to be an acute or unusual awareness of normal bodily functions which the patient misinterprets as symptoms.

Occasionally, a very significant symptom is uncovered only through the review of systems. In patients with coronary insufficiency precipitated by gastrointestinal bleeding, the history may be uncovered only by the review of systems, i.e. by asking specifically about the passage of tarry stools.

Depressive Reaction

A review of systems will also uncover the almost specific symptoms of a depressive reaction and the physician should be acutely aware of the etiological relationship between certain types of bizarre, constant abdominal pain and the depressive syndromes. Such pain may disappear with the treatment of depression by electro-shock therapy or the anti-depressant drugs.

To evaluate adequately the complaint of abdominal pain there are a number of specific questions that must be answered. The type of onset, the severity of the pain, the duration of the pain, and the character of the pain are factors that must be ascertained.

Variations

The intensity and time characteristics of abdominal pain may vary with the organ involved and the pathological process. (Figures 2-5) The cyclic nature of pain arising in the small and large bowel is illustrated as well as the differences in the timing of their cycles. Also illustrated is the more sustained nature of the pain from pancreatitis and peptic ulcer and cholelithiasis. A knowledge of these differences in time of onset, the presence or absence of cyclic variations in intensity and the timing of pain cycles can be helpful in the differential diagnosis of abdominal pain.

The relationship of the pain to meals, defecation, breathing, and coughing, exercise, specific food, the passage of flatus, gaseous eructation, urination, position, movements of the spine, and menstrual flow is very important. The location of the pain is of obvious importance but may be misleading, because an oc-

casional patient may fail to notice whether the pain is above or below the umbilicus or whether it is to the right or to the left. Patients with gallbladder colic occasionally designate the right lower quadrant as the location of their pain. Patients with uncomplicated peptic ulcer occasionally refer uncomplicated ulcer distress to the lower abdomen. The presence of fever and chills with the abdominal pain suggests pyelonephritis, acute salpingitis or acute endometritis or acute cholangitis. Additional facts that may be of diagnostic importance include the radiation of pain, the time of day that episodes of pain occur, and the setting in which the pain has its onset. Great variation in the location of abdominal pain is very suggestive of functional disorder.

Diagnostic Possibilities

The diagnostic possibilities of pain in various quadrants of the abdomen should be reviewed. Acute or chronic pain in the epigastrium may be manifestations of coronary artery disease or myocardial infarction, acute or chronic peptic ulcer, acute cholelithiasis, pyloric obstruction, pancreatitis, hiatus hernia, and the initial phases of acute appendicitis. Pain in the right lower quadrant may be a manifestation of acute diaphragmatic pleurisy, pancreatitis, liver abscess, hepatitis or hepatic congestion, acute cholecystitis, inflammatory or neoplastic lesions of the ascending colon and splenic flexure, and right renal disease.

It is especially important to emphasize that the pain of ureteral colic from a stone in the right ureteral-pelvic junction and the pain of hydronephrosis and acute pyelonephritis may be referred to the right upper quadrant rather than primarily in the right flank and right costovertebral angle area. It should be emphasized that severe right upper quadrant pain from diaphragmatic pleurisy has been confused with acute cholecystitis.

Lesions manifesting pain in the left upper quadrant of the abdomen includes renal and pleural lesions as previously noted, splenic infarction, pancreatitis, inflammatory or neoplastic lesions of the transverse colon and the splenic flexure, the functional splenic flexure syndrome and disorders of intercostal nerves and chest wall.

In its early stages herpes zoster involving the

Figure 2

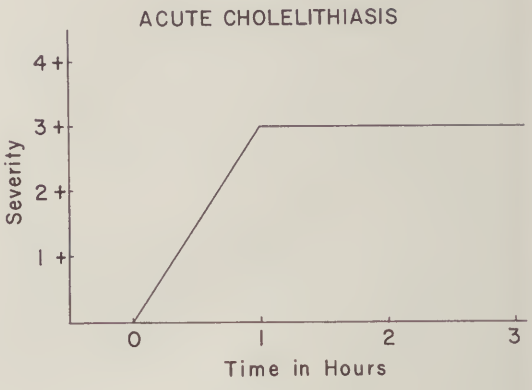


Figure 3

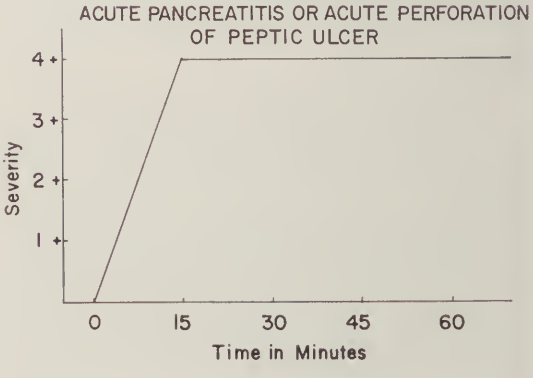


Figure 4

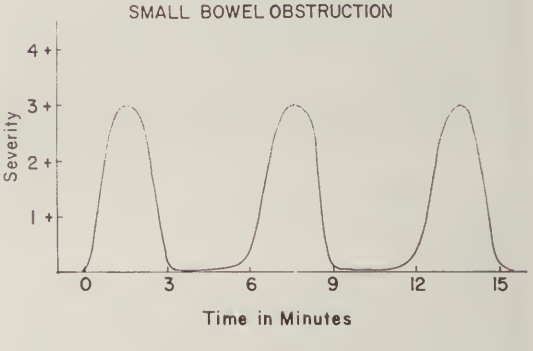
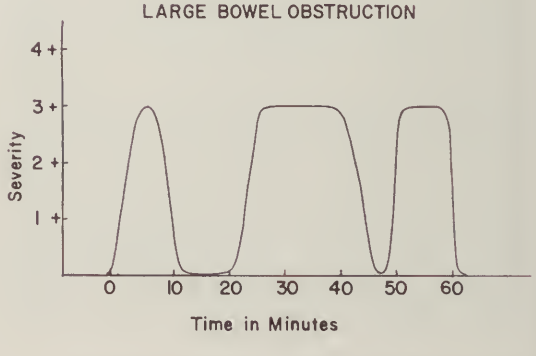


Figure 5



lower thoracic and upper lumbar spinal nerves may present as a confusing picture of abdominal pain which is occasionally misinterpreted as acute cholecystitis or ureteral colic. Pain in the periumbilical area is usually a manifestation of inflammatory or neoplastic diseases of the small bowel or the appendix and small bowel obstruction.

Pain in the right lower quadrant may be a manifestation of acute appendicitis, inflammatory or neoplastic disease of the terminal ileum and cecum, acute salpingitis, tubal pregnancies, ureteral colic, other right tubal or ovarian diseases, and inguinal and femoral herniae. Pain in the left lower quadrant may be a manifestation of ureteral colic and tubal and ovarian diseases as previously noted or it may be a manifestation of functional diseases of the descending and sigmoid colon, neoplastic and inflammatory diseases of the descending and sigmoid colon, particularly acute and chronic diverticulitis. And one should keep in mind that acute diverticulitis may occur without a functional disturbance of the colon and rectum.

Pain of Metabolic Origin

Occasionally, pain in the lower quadrants of the abdomen is the result of acute or chronic inflammation of the seminal vesicles. Abdominal pain of metabolic origin is usually diffuse and generalized, such as that which is seen with acute, intermittent porphyria. In addition, such pain is usually not accompanied by rebound tenderness or pain and involuntary muscle spasm.

An accurate diagnosis of abdominal pain can seldom be made from the abdominal examination alone. The examination confirms or supports the clinical impression or makes necessary the re-evaluation of the clinical history. However, the presence or absence and location of tenderness, mass formation, rebound pain, and involuntary muscle spasm are important confirmatory findings. The presence of herniae, visible peristaltic waves, succussion splash over the stomach (fasting or more than six hours after meals), friction rubs over the spleen, a palpable or distended gallbladder in the presence of jaundice, hemorrhagic discoloration of the umbilicus or flanks and the presence of large, firm, irregular nodules in the liver, are of more specific diagnostic value.

Gaseous abdominal distention without peristalsis may occur in any painful abdominal disease, in numerous metabolic disorders, and in a few functional disturbances. It, therefore, is of little diagnostic value. However, when the distention is due to free fluid or ascites, the field of diagnostic possibilities is considerably narrowed. During the abdominal examination one should obtain some objective evidence of the patient's pain threshold since it is of great importance in evaluating the actual severity of abdominal pain.

Following the completion of diagnostic studies, a correlation of the findings of the clinical history and physical examination with the x-ray and laboratory findings must be made, and care should be taken that this correlation is a logical one. Roentgen findings of the gastrointestinal tract are very valuable aids to the diagnosis of abdominal pain, but they can be and often are misleading.

Limitations of Tests

The finding of a duodenal deformity on an upper GI series does not explain pain in the right upper quadrant which is characteristic of acute cholecystitis. Negative roentgen examinations are often present in patients with peptic ulcer of short duration and in an occasional patient who has been symptomatic for several years. Moreover, unequivocally positive roentgen findings of a duodenal ulcer can be present in patients who, on surgical exploration, have no ulcer. A completely normal cholecystogram may be present in a patient with characteristic attacks of gallstone colic and multiple calculi at exploratory laparotomy. In a recent series of 312 cases of chronic cholelithiasis reported by the late Dr. W. H. Pennington and Dr. Wallace Herrell at the Lexington Clinic, there were 10 such patients with characteristic gallbladder colic, negative x-rays and calculi at exploratory laparotomy. Therefore, if a laboratory test or x-ray finding does not fit the clinical picture, the physician should re-evaluate the history and repeat the laboratory tests or x-ray studies. These facts are not intended to be criticisms of the clinical laboratory or the roentgen method; they merely point out the limitation of any diagnostic test or x-ray study.

Despite the accuracy of any good method of

evaluating and determing the causes of abdominal pain, there are certain groups of patients that remain a problem in diagnosis. For instance, atypical abdominal pain with unimpressive physical findings, negative roentgen studies, and non-diagnostic laboratory studies, is usually attributed to a functional disturbance. In a majority of patients with such pain and findings this decision is correct. However, care must be taken to consider the possibilities of acute, intermittent, porphyria, hemolytic crises, essential hyperlipemia, abdominal epilepsy, so-called abdominal migraine, intermittent small bowel ischemia from atherosclerosis or acute angitis of the superior mesenteric artery, referred pain from myocardial ischemia, a fecalith of the appendix with intermittent obstruction, blind loop obstruction in patients following subtotal gastric resection, chronic lead intoxication, poisoning from back widow spider bites and Tabetic crisis.

Finally, there are a few patients with apparently disabling abdominal pain who have had exhaustive studies with negative results. Such patients should be subjected to exploratory laparotomy to rule out disease that defies the usual diagnostic armamentarium.

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Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

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Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

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Differential Diagnosis Of Abdominal Pain: Neuropsychiatric Aspects

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WE SAY THAT a patient has "abdominal pain" when he complains to us that "it hurts" anywhere in the general area of the body from below the diaphragm to above the pubic symphysis, towards the front of the body. Determining the source of this complaint is a vital step towards the differential diagnosis of various disorders. From the psychiatrist's point of view there are certain basic principles to be kept in mind when the patient points to his belly area and says "it hurts."

It is important to recall that even when abdominal pain is caused by some organic lesion it may not arise from an abdominal organ, or an abdominal organ in the area of the pain. The phenomenon of "referred pain" may then be present.

Somatic Delusion

Even when some abdominal organ is damaged or malfunctioning, it may not be sufficient to explain the state of the patient. For example, a patient whose parent has died of cancer of the stomach may complain of very severe stomach pain with a mild digestive upset. Thus he can mask a panic that he too has developed cancer of the stomach, and attempt to interest the doctor into hospitalizing him and doing all sorts of diagnostic tests. The extreme of this is the "somatic delusion," where the patient has no damaged or malfunctioning abdominal organ at all, but has the delusion that something is dreadfully wrong in the abdomen. These patients may present with the complaint of abdominal pain of varying degrees. Sometimes it is easy to make the diagnosis of a psychotic state by listening to the patient, e.g. "I am rotting away inside and worms are eating me up." Sometimes, however, the diagnosis may be very difficult to arrive at because the patient is knowledgeable and covers up his secret delusion. Rather frequently, there is the hope that the doctor *will* find something to confirm the patient's delusional beliefs. Unfortunately, the physician may fall into the trap of mentioning questionable or borderline laboratory findings to the patient, which the latter then eagerly weaves into his delusional system.

Cerebral Element

The concept of "pain" *always* contains a cerebral element which, except in the most clear-cut cases, should be considered in trying to make the differential diagnosis of this condition. To make this clear, we will present a brief review of the neuroanatomical connections in the abdomen.

The autonomic nervous system comprises all the efferent nerves through which the visceral organs are innervated. The conduction pathways from the central nervous system to the visceral organs are made up of preganglionic (solid) and postganglionic neurons (dotted). The cell bodies of the postganglionic neurons are arranged in aggregates known as autonomic ganglia. These cells are activated through impulses received from the preganglionic cells, passed across the synapses in the autonomic ganglia between the preganglionic cell axones and the postganglion cell dendrites. Thus a single postganglion cell may be synaptically related to more than one preganglionic neuron.

Some of the preganglionic neuron cell bodies for the abdominal viscera are located in the spinal cord, in the lateral portion of the gray matter of the thoracic and first two lumbar segments. These extend via the splanchnic nerves

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to large ganglionic plexuses such as the celiac, superior or inferior mesenteric ganglia, where they synapse with the postganglionic fibers. This constitutes the sympathetic part of the autonomic nervous system outflow.

Other preganglionic fibers come from the brain stem and the sacral part of the spinal cord and synapse in ganglia in close proximity to the viscera they innervate. This constitutes the parasympathetic part of the autonomic system outflow. Most abdominal viscera are supplied with both sympathetic and parasympathetic effector fibers.

The autonomic nervous system does not include nerve components which conduct impulses into the central nervous system. The afferent neurons which conduct impulses from visceral organs to the spinal cord and brain stem are visceral afferent components of the spinal and cranial nerves. The cell bodies of these neurons, like those of the somatic afferent neurons, are located in the ganglia associated with the sensory roots of the respective spinal or cranial nerves. The visceral afferent nerve fibers in general traverse the autonomic ganglia but make few synaptic contacts in them.

Reflex Connections

Both visceral and somatic afferent nerve fibers make reflex connections with preganglionic autonomic neurons in the spinal cord and brain stem, and the major portion of the neural regulation of visceral functions is carried out through reflex mechanisms with their central connections in the spinal cord and brain stem. Thus the simplest autonomic reflex arc consists of an afferent conductor which may be either a visceral or somatic afferent neuron, a synapse in the spinal cord, and an efferent conductor made up of a preganglionic and postganglionic neuron.

As with the classic somatic reflex arc, influences from the brain stem and cerebral cortex exert an important regulatory influence on autonomic reflex functions. These cerebral influences are usually mediated through the hypothalamus, which may be thought of as the central or "head" ganglion of the autonomic nervous system, and which sends impulses that flow down the spinal cord via the thalamus and reticular formation.

The nerve structures transmitting pain are different from other afferent fibers conducting heat, cold, touch or pressure. Visceral pain fibers, although they pass like other visceral afferent fibers through the sympathetic ganglia en route to the spinal cord, do not differ from somatic pain fibers. Somatic pain fibers from the parietal peritoneum run in the intercostal nerves.

Pain Impulses

Pain impulses are transmitted along the primary sensory neurones into the posterior horn of the spinal cord. After synapse, the secondary sensory neurons cross to the opposite side of the cord almost immediately and combine to form the lateral spinothalamic tract, which rises up and terminates in the posterolateral ventral nucleus of the thalamus. The third sensory neuron conveys the impulse from the thalamus to the cortex of the postcentral convolution.

While pain from the skin may be well localized, pain from deep structures may be referred remotely. There are two schools of neurophysiological thought on the explanation of referred pain; those who believe the mechanism is located in the central nervous system and those who attribute this phenomenon to events in the periphery. The branching of axones seems to be vital to the production of referred pain. This branching is of such a type that one limb of a branched axon passes to the site of origin of the disturbance, and others pass to sites to which the pain is referred. This may lead to misinterpretation by the central receiving apparatus of the source of the painful impulses, and also the production in the periphery of antidromic impulses which stimulate and damage nerve endings, giving rise to secondary pain impulses (from the other remote branches of the axon).

Clinical Observations

The cerebral aspects of abdominal pain are not only evident through the well-known influence of the brain on spinal reflex structures via the spinal cord and perhaps via neurohumors, but through a variety of experimental and clinical observations. For example, certain drugs such as morphine and chlorpromazine have been shown experimentally to have no effect on the pain-producing process itself. Their major action is on the cortical aspects of pain.

Morphine, for example, in experiments at the Addiction Research Center in the U. S. Public Health Service Hospital at Lexington, has been shown to reduce the anxious apprehension involved in the anticipation of pain. Its analgesic effect is probably at least partly due to this action. Chlorpromazine was described by its discoverer as inducing a "lobotomie pharmacologique," that is to say inducing an effect similar to a prefrontal lobotomy, with the result that painful stimuli are ignored or borne with great equanimity. Similarly, the enormous variation in pain threshold among individuals without the influence of drugs is well-known, varying from the stoical Indian to the perpetually complaining hypochondriac.

Differential Diagnosis

Therefore, it is a mistake to speak of "functional" and "organic" abdominal pain. In our differential diagnosis it is possible only to speak of "pain as part of a recognized syndrome of organ disorder," e.g. the gnawing pain of a peptic ulcer in the center of the abdomen occurring at certain intervals of the day and relieved by meals, etc., and "pain as not part of a recognized syndrome of organ disorder." More characteristic of the latter type of pain are vagueness of complaints, history of many negative procedures in the past, and frequently of many surgical operations on the abdomen with no relief. Also indicative are the following: dramatic or bizarre complaints or ways of complaining, inconsistent or contradictory history, a tendency to attribute all troubles to various malevolent beings, peculiar speech with sometimes subtle mistakes in logic, lack of any sense of humor, associated reports of bizarre dreams or other body sensations, a surprising paucity of planning for the future on the part of the patient, and the conveyance of a feeling to the doctor by appearace or demeanor that something is not right about the patient.

The more that the pain is not characteristic of classical organ syndromes in location and intensity, the more effort must be made to determine the specifical psychological meaning of the pain. Most often, this meaning will involve the plea for help with some problem of living that the patient has, and this problem may actually overshadow any organic disorder that is present, in being responsible for the patient's complaint of pain. Careful attention should be paid to somatic and psychological manifestations of depression.

Often it is difficult to determine what is happening in the patient's life. At this point it is valuable for the general physician or surgeon to call in someone who is a trained listener, namely, the psychiatrist. He will usually find that the pain, besides involving a request for help, represents a complaint about being unfairly treated by a significant family member, and/or attack and retribution against a needed but unconsciously hated object. Introduction of opiates for such pain by the physician may result in the disaster of narcotic addiction.

Summary

In summary, the cerebral structures have an overwhelming influence on when the patient does or does not present himself to the physician with the complaint of pain in the abdomen. Therefore, in making the differential diagnosis of abdominal pain, whether there is demonstrated organic damage or not, it is important to keep in mind what the patient means by his complaint. This may be especially true of pain complaints associated with such a wide variety of conditions, ("functional" *or* "organic"), as nervous dysphagia, globus hystericus, cardiospasm, peptic ulcer, regional enteritis, mucous colitis, ulcerative colitis, constipation, hyperemesis, anorexia nervosa, and narcotic addiction. A bit of careful listening by the busy physician may save the patient a lot of money and confusion, as well as avoid a lot of unnecessary procedures that inconvenience both the patient and physician.

Celiac Syndromes

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IN RECENT YEARS a great many advances have been made in the field of malabsorption. Only through better understanding of the physiology of absorption are we now able to classify this broad clinical syndrome. A good

FIGURE 1
Failure of Proper Digestion
Resulting in Malabsorption

I. Inadequate mixing
  - Subtotal & total gastrectomies
  - Pyloroplasty

II. Inadequate panc. enzymes
  - Cystic fibrosis
  - Chronic pancreatitis
  - Ca of pancreas & ca of ampulla
  - Pancreatic fistula

III. Inadequate emulsification
  - Severe liver disease
  - Obstructive jaundice

classification is not only helpful in understanding the basic pathophysiology of the different disease states but it is also extremely useful to the practicing physician in the differential diagnosis and frequently the management of patients with malabsorption.

When speaking of malabsorption we obviously are not dealing with a single disease entity, but actually a heterogeneous group of diseases with one thing in common, and that is an increase fecal excretion of rarely one, but usually many, and sometimes all of the nutrients.

It is customary to include diseases of digestion in discussing malabsorption, even though technically they are not diseases of absorption (Figure I). The end result, however, is the same, i.e. malnutrition and increase in the fecal output of nutrients. Under this category—failure of proper digestion—there are: Inadequate mixing of foods with the digestive enzymes as a result of subtotal or total gastrectomy; inadequate pancreatic lipase and different proteases due to cystic fibrosis of the pancreas, chronic pancreatitis, malignancies of the pancreas or the ampulla; pancreatic fistula or severe protein malnutrition itself; and inadequate emulsification due to lack of bile salts, which could result from severe liver disease or chronic, or even acute, obstructive jaundice.

True malabsorption has to do with diseases of the small bowel and it is pathophysiologically divided into three groups—the primary, the secondary, and a group which is drug induced (Figure 2).

FIGURE 2
Failure of Proper Absorption
True Malabsorption

I. Primary
  - Celiac disease
  - Tropical sprue
  - Non-tropical sprue

II. Secondary
  - A. Inadequate length of absorb. surface
    - Surgical resection
    - Internal fistula
  - B. Mesenteric lymph. blockage
    - Lymphomas
    - Carcinomas
    - Whipple's disease
  - C. Ext. mucosal destruction
    - Reg. enteritis, tbc enteritis
    - Malignancies
    - Scleroderma
    - Amyloidosis
  - D. Assoc. with strictures, diverticula and blind loops
  - E. Assoc. with infections and infestations
  - F. Assoc. with severe malnutrition

III. Drug induced
  - Neomycin
  - Anion-exchange resin (MK-135)
  - Laxatives
  - ? X-ray, cytotoxic agents

I. Primary

Under the primary type there are three well known disease entities—celiac disease, nontropical sprue, and tropical sprue.

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II. Secondary

Surgical resection of sufficient amount of small bowel and the presence of internal fistula between the upper and the lower gastrointestinal tract due to different diseases often result in significant malabsorption due to inadequate length of absorbing surface. Obstruction of the lymphatic drainages from the small bowel could also give malabsorption. This can be due to lymphoma, carcinoma, and Whipple's disease. Extensive destruction of the mucosa as a result of inflammatory diseases such as regional enteritis and tuberculous enteritis and neoplastic diseases or infiltrative diseases such as scleroderma or amyloidosis can also result in gastrointestinal malabsorption.

Rarely, malabsorption sometimes is due to strictures, diverticula and blind loops of the small bowel. Malabsorption of a transient nature can occur in association with infections, either viral or bacterial. It can also be due to infestation with different parasites. Malabsorption in the small bowel can be the result of severe malnutrition.

III. Drug Induced

This is a very interesting group for two reasons. First, an opportunity is afforded to study the physiology and the pathophysiology of intestinal absorption, especially since most of the drugs only cause a reversible and temporary state of malabsorption. Secondly, this probably will be a rapidly growing group with all the new drugs appearing on the market every day.

Neomycin has been well studied in this regard. It has been reported by a group from Syracuse to show evidences of malabsorption in a matter of 4-6 days on a dosage which is quite compatible with the dosage usually used in clinical practice. There is malabsorption of many different foodstuffs, including fats, proteins, vitamins, and carbohydrates. One of the interesting drugs under the code name MK-135, used for lowering the serum cholesterol by binding bile acids and bile salts in the gastrointestinal tract, has also been shown to cause steatorrhea.

Laxatives can cause not only malabsorption through the loss of water and nutrients, but can also produce nephropathy due to loss of K+ ion in the stools. Some of the laxatives have been shown to cause a decrease absorption of other food substances as well. There is a question whether x-ray and other cytotoxic agents such as the antifolic agents are able to produce malabsorption in the human even though it has been shown in the rat that many antifolic agents can produce severe destruction of the gastrointestinal mucosa.

Primary malabsorption of the small bowel is one of the most important types recently studied in detail. In this group are Celiac disease, non-tropical sprue, and tropical sprue. As we understand it now, these diseases are probably genetically transmitted. It is now generally agreed that celiac disease and non-tropical sprue are one and the same disease. Celiac disease is seen in children and non-tropical sprue, the same disease, is seen in adults.

Whether tropical sprue is also one variation of the same disease is a question unsettled at the moment. Dr. David Adlersberg of New York City feels that tropical sprue is the same disease as the other two. Many others, however, especially the British group, believe that tropical sprue and non-tropical sprue are two quite distinct diseases.

Important Advances

Important information has been added recently to the better understanding of this group of diseases. A few of the more important advances which have occurred in the past decade shall be briefly outlined.

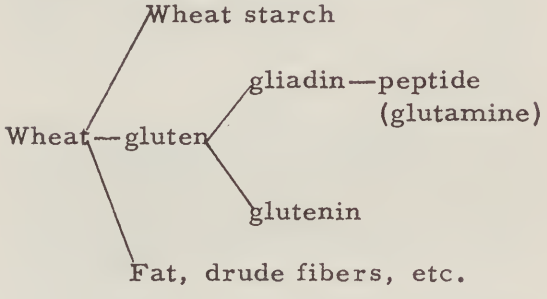
ACTH and the adrenal steroids came into use in the late 1940's and the early 1950's. They were found to be effective in the treatment of patients suffering from non-tropical sprue. However, in recent years, ACTH and adrenal corticords have been largely replaced by the use of the wheat-and-rye-gluten-free diet in the management of non-tropical sprue.

In 1949, it was shown by a group of Dutch workers (Weijers, van de Kamer, and Dicke) that wheat was the injurious substance to those suffering from celiac disease and by eliminating wheat and rye (which was later found also to contain the injurious substance) they could produce a remission in children with celiac disease. Two years later this regimen was tried on patients with non-tropical sprue and a similarly dramatic improvement resulted.

Much work has been done in the past few

ycars in the further delineation and characterization of the substance that is contained in wheat and rye. A great majority of the information thus far obtained has been the result of investigation done by the British and Dutch workers. They found that gluten contained in wheat and rye was the substance responsible for the symptoms in celiac disease and adult celiac disease (Figure 3). By further hydrolysis of this substance, they found the gliadin fraction of gluten the injurious agent. Further separation has led to the conclusion

FIGURE 3
Hydrolysis of Wheat and Gluten



that the substance responsible for the production of the symptoms in patients with celiac disease and adult celiac disease is a glutamine containing peptide. Work is still going on to further delineate the nature of the injurious substance. This has certainly been a breakthrough in the study of the basic biochemical changes in this group of diseases.

One of the other very important contributions in the study of this group of diseases is the establishment and characterization of a fairly specific anatomical lesion of the jejunal mucosa. This has been possible only through the development of efficient intestinal biopsy instruments and through the high resolving power of the electron microscope.

It has been shown that it is the microvilli of the intestinal mucosa that are at fault and that their atrophy may be the basic anatomical lesion responsible for the difficulties in absorption. It has been estimated that one single epithelial cell of the small bowel mucosa normally has about 3600 microvilli projecting into the lumen of the small intestine. These are responsible for the normal absorption of nutrients. It is not difficult to imagine that the atrophy of the microvilli leading to a much decreased absorbing surface could be responsible for the clinical signs and symptoms of malabsorption.

Great strides have been taken in answering many of the basic questions, but many more questions are still unanswered. For example, it is not certain whether tropical sprue is indeed the same disease as non-tropical sprue. What is the exact relationship between gluten and the anatomical lesions seen in the small bowel mucosa? What does gluten or glutamine containing peptide have to do with folic acid metabolism and vitamin C metabolism? Are the intestinal lesions indeed irreversible? Some of these questions will probably be answered by time alone, some of them will be answered by further laboratory and clinical work, and many probably will not be answered for a long time to come.

Parasitism And Intestinal Malabsorption

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INTESTINAL parasites are almost always listed as a cause of the celiac syndrome in standard pediatric texts. However, although one may turn through many pages written about Celiac disease and Fibrocystic disease there is usually only a short paragraph on parasites mentioning that Giardia Lamblia is sometimes a cause of Celiac syndrome. As far as other parasites are concerned, the general texts are veiled in mystery except for Brenneman[1] who states that Ascaris is a cause.

Faced with a dearth of printed information I should like to discuss the subject of "Parasitism and Malabsorption" under these headings.

(1) A discussion of Giardia as a cause of malabsorption.

(2) A review of intestinal parasites which might be encountered in this geographical area and what is known of their importance as a cause of malabsorption.

(3) A review of children admitted to the Pediatric Service of the Harlan Memorial Hospital in Harlan, Kentucky, during 1958 and 1959. The children with stools positive for ova and/or parasites will be compared with those who had negative stools to learn if there was any difference in nutrition as reflected by height and weight percentiles and as evidenced by anemia.

(4) And finally, a review of two unusual cases in this group of patients.

Although known to be pathogenic for 80 years, Giardia was not fully studied and described as a cause of parasitic diseases in children until 1938 when a Hungarian pediatrician, Veghelyi, published the results of a controlled study on a large series of children.[2]

In symptomatic patients, enormous numbers of these organisms in the vegetative stage adhere to the epithelial cells of the duodenum and upper jejunum. Veghelyi found symptoms of disease in 3/4 of those children infested. Diarrhea is usually the first symptom and this is sometimes followed by a recurrent or chronic illness, the principal features of which are anorexia, recurrent abdominal pain, diarrhea, loss of weight and anemia. In the rare heavily infested cases, with much diminution of the absorptive surface of the upper bowel, features characteristic of the Celiac syndrome may also develop, notably steatorrhea and abdominal distention.

Four Cases Presented

Frank disease due to Giardia is occasionally described in the United States. Most recently in the September '59 Journal of Diseases of Children, Dr. Jean Cortner of Nashville presented four cases.[3] These four cases had clinically manifest malabsorption. Their response to therapy with Quinacrine was unmistakable. Dr. Cortner attempted to prove that Giardia infestation interfered with absorption by doing Iodine 131 labelled "fat absorption tests" before and after quinacrine therapy in two cases. In one the improvement was clear cut and progressive at one and eight months after therapy. The other showed improvement five months after therapy, but the author was unable to do further follow-up studies.

Dr. Cortner's article noted that one child was followed for several years in a large Celiac Clinic before the correct diagnosis was established. Other cases were not diagnosed until repeated stools examinations were performed, pointing up the need for multiple stool examinations (or duodenal aspiration).

Since this is a form of malabsorption highly responsive to therapy with Quinacrine used for 5 days, one should search for Giardia in every

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case of Celiac syndrome. (The author's dose ranged from 100 mgm. to 150 mgm. daily in children.)

Intestinal parasites which might be encountered in Kentucky, are listed as follows:

Protozoa
E. Histolytica
Giardia Lamblia*

Nemathelminthes
Ascaris*
Enterobius
Necator
Strongyloides*
Trichuris*

Platyhelminthes
Taenia Saginata
Taenia Solium
Dipylidium Caninum
Hymenolepsis Nana*

*Isolated from patients in Harlan, Kentucky

Among those listed, there is no mention in the literature of tapeworms as a cause of the malabsorption syndrome. Among the protozoa, reference has already been made to Giardia. Amoebae can cause thickening and scarring of the intestinal wall with chronic dystentery and weight loss but there is no known description of the production of a Celiac-like syndrome.

Suspects Listed

When the roundworms are considered, the subject is uncertain. In 1928, Dr. Fanconi of Zurich, Switzerland, stated that Ascaris could be a cause of Celiac syndrome.[4] In 1959, J. L. Henderson stated in "The Practitioner" "severe untreated ascariasis, as occasionally seen in the tropics, may also be a cause of the celiac syndrome."[5] No other roundworms are mentioned as a cause of malabsorption but if ascaris can be involved, it is reasonable also to suspect Strongyloides, Trichuris and Necator.

When considering the roundworms, it is of interest to note a paper by Einhorn and Miller in 1956.[6] In reviewing 618 children in the Canal Zone and Panama with intestinal roundworms (including an extensive study of symptomatology) there were no cases of malabsorption syndrome described, although many children were malnourished. The paper discussed patients infested with Ascaris, Trichuris, Oxyuriasis, Strongyloides, and Ancylostoma.

The heavily infested child is usually the resident of a poor living area and is usually inadequately nourished. Under such circumstances it is very difficult to know whether the malabsorption syndrome is due to parasitic infestation or is an associated finding more closely related to malnutrition. Craig and Faust[7] make an interesting comment on this point. They refer to a study in the tropics where children with severe Necator infestation were given a balanced diet with added iron and liver. These children did not develop anemia or malnutrition, while both are usually seen in advanced hookworm infestation. Considering such patients as these, some cases of intestinal malabsorption associated with infestation may actually represent malnutrition in a child incidentally infested with parasites.

In 1958 and 1959 there were 256 patients over the age of one year admitted to the Memorial Hospital Pediatric Service. Table I shows the distribution of parasites encountered. Of these, 165 had a stool examined for ova and parasites; 34% of those tested had positive results. At present, only one stool specimen per patient is examined for ova and parasites as a routine. If every child had 3 or 4 examinations

TABLE I
Parasites Seen in 56 Children
1958 and 1959

Ascaris	45	Hymenolepis	1
Trichuris	18	Giardia	1
Strongyloides	3	Oxyuriasis	3

the percentage would be much higher. Three stools are examined only if specifically looking for worms. In the 56 positive specimens, 45 revealed Ascaris; 18 Trichuris; 3 Strongyloides; 1 Hymenolepsus; 3 Oxyuriasis; 1 Giardia. All but one of these patients were admitted with a primary diagnosis other than worms.

If roundworms are an important cause of malabsorption in children one might expect the infested children to show some difference as a group from the non-infested.

To see if this were true we collected three sets of figures (when available) for the 165 children, taking each child's admission height, weight and microhematocrit, and then comparing the two groups.

Heights and weights were compared by using the Harvard grid for children from 2-13. Two age groups were used for hematocrit (2-6yrs. and 7-12 yrs.) and these were compared with the optimal values for healthy children in Wolman's Pediatric Laboratory Text.[8]

In tabulating heights and weights in per-

TABLE II
Placment Of Children In Harvard Grid Percentiles

Grid Percentiles 2 - 13 yrs.	GIRLS				BOYS			
	Height		Weight		Height		Weight	
Stool for O&P	Pos.	Neg.	Pos.	Neg.	Pos.	Neg.	Pos.	Neg.
3% or below	31.6	27.6	31.6	20.6	20.0	31.8	13·3	21.2
10% or below	52.6	37.9	51.8	47.1	70.0	45.4	40.0	30.3
25% or below	68.4	62·2	65.5	70.5	80.0	59.1	73.4	36.4
50% or below	79	75.8	82.7	85.4	100.0	68.2	93.4	63.6
75% or below	94.3	93.2	96.6	97.0		91.0	93.4	81.8
90% or below	100.0	100.0	100.0	97.0		95.5	100.0	91.0
97% or below				97.0		95.5		97.0
Above 97%				100.0		100.0		100.0
Number of Pts.	19	29	29	34	10	22	15	33

centiles by age there was no significant difference. Both groups of children (all in patients) were smaller than one would expect according to the Harvard Grid. Perusal of the data for infested and non-infested children showed only that children sick enough to be admitted to the hospital in Harlan are smaller than normal children studied for the Harvard Grid. They do not prove any difference of note in our two groups. (Table II)

In measuring hematocrits, our two groups from 2-6 years were quite close. The 7-12 year groups differed slightly but with such a small group of patients the differences did not even seem to warrant statistical analysis. (Table III)

TABLE III
Hematocrit Values

Optimal Value	Hospitalized Pediatric Patient		
Healthy Child	Stool Pos. for O & P		Stool Neg. for O & P
2-6 yrs	38	37.4 (19 pts)	36.8 (41 pts)
7-12 yrs	41	*37.7 (22 pts)	39.6 (28 pts)
		*36.5 (23 pts)	

* 1st figure excludes child infested with 4 parasites with Hematocrit of 5.

It is our present opinion after reviewing the clinical records of these 165 patients that roundworms are not a frequent cause of malabsorption syndrome, or of malnutrition.

Of the 56 children studied, two were of special interest and intestinal parasites probably played a major role in their illness. F. F. was first admitted at 20 months because of diarrhea, fever, cough and a running ear. Her birth weight had been 7 lbs. 4 ozs. She had been a slow baby, walking at 18 months and talking at 20 months. Her father was unemployed and had almost no income. She ate whatever food was available, had received no vitamins and no immunizations. She had always been small compared to her siblings.

Admission physical revealed a dehydrated baby with a sunken fontanelle, dry lips and skin, poor muscle mass of her arms and legs and a pot belly. She was very irritable. Her temperature was 101°, her weight was 15½ lbs. (20 mo.) She had a suppurative otitis media.

Studies—X-ray (chest) Pneumonia; Bone age 18 months (normal)
CBS—28 hematocrit. WBC 10,500. 15% Eosinos.
Stools—Strongyloides ova present.
Urine, total protein and A/G Ratio, NPN, Sweat Na & C1 were all normal.

The diarrhea, otitis media and pneumonia responded to therapy in two - three days. The baby was given a course of Piperazine Citrate. By the third week in the hospital she was eating well on a full diet but was fussy, had bulky stools and a pot belly. Her hematocrit went to 36 on oral iron. She was discharged to be followed as an out-patient with the diagnosis of Celiac syndrome secondary to malnutrition.

At 26 months she was again admitted because of diarrhea. She again was the same poorly developed irritable child with poor muscular development and a pot belly. Her weight was 19 lbs. (One ounce over her discharge weight 5 months earlier).

Lab: Hematocrit 37, 17,100 WBC; 11% Eos:
Stool—Strongyloides ova present.
Prot. & A/G Ratio—normal

The diarrhea responded to therapy in two days. She then had four - five bulky stools a day. They were foul in odor and often contained undigested food particles. On her 8th day she was started on Dithiazanine Iodide (Delvex) 100 mgm b.i.d. for 16 days. All during her therapy she had bulky stools. She had a marked change in her personality by the 10th day of therapy, becoming a very happy child. At the onset of therapy she weighed 19½ lbs. and by the 12th day of treatment 20 lbs. One week after completion of therapy she weighed 21 lbs. For one week before going home all her stools were normal, and she was happy. She had gained two pounds in one month and lost her pot belly.

The Symptoms

This little girl fits the old description of Celiac syndrome as outlined by Samuel Gee in 1888[7]:

1. Pale, bulky, offensive stools.
2. Abdominal distention.
3. Wasting.
4. Stunting of growth.
5. Anorexia.
6. Clinical Evidence of vitamins and mineral deficiency.

Although she had improved on diet, this child did not fully recover until rid of her parasitic infestation. Although she seems to be a good candidate for the diagnosis of malabsorption syndrome secondary to Strongyloides, other factors during her stay could have been responsible for her cure. It is of interest that this one child with the Celiac syndrome was infested with Strongyloides.

Strongyloides like Giardia has a predilection for the duodenum and upper intestine while the other round worms are commonly found further down in the intestine. This fact is well shown by Jones[9] who made the observation in 100 cases of Strongyloides, that 91% had positive duodenal aspirations while only 27% had positive stools.

Second Patient

The second patient does not fit into the Celiac syndrome but she is a dramatic example of severe nutritional failure, apparently related to intestinal parasites.

A. W. is a 11½-year-old girl referred to our service because of pallor and paralysis. She had had weakness for one month and had been unable to walk for one week. Recently she had passed 92 worms.

Admission physical revealed a small undernourished, very pale, white female 47 inches tall and weighing 47 lbs. Pulse was 132, blood pressure 110/40-0. She had cardiac enlargement with the AB in the AAL in the 5th LS. She had a loud systolic murmur at the apex and base and a diastolic murmur at the base. Her liver was palpated 3 cm. below the costal cage. Neurological exam revealed that both lower extremities were spastic, she had generalized weakness with inability to stand. She had hyperactive KJ and AJ, ankle clonus and bilateral Babinski. Laboratory data were as follows:

Hematocrit 5%
Hemoglobin 1.8 gm.
R B C 760,000
W B C 3,100 with 9% Eosinophiles, 41 segs., 40 lymphs, 2 monos.

Serum Protein
Serum Bilirubin
Ceph Floc
Thymol Turb
Reticulocyte Count
Platelet count
All within normal limits

Serum Iron 87 micrograms (Norm 80-150)
Blood Culture - negative
EKG - normal
Bone Marrow - no abnormalities
Chest x-ray - Cardiac enlargement
Skull x-ray - negative
Stools for occult blood - negative
Stools for O & P Loated with Trichuris
Strongyloides
Enterobius
Ascaris

The patient was given 100 cc of packed red cells after the above studies and the next morning another 100 cc of packed cells. The following day she received 250 ccs of packed red cells (450 cc. total). This raised her hematocrit to 27 and her hemoglobin to 8.

The patient was started on Imferon and oral Iron + Vitamins. For her roundworm infestation Delvex 500 mgm. was given daily in divided doses. Twelve hours after her first 100 ccs of blood, all of the neurological signs disappeared. The child was up and walking after her second 100 cc. Her murmurs decreased and on the day of discharge (11 days after admission) only a soft systolic murmur was heard at the base and heart size was normal by x-ray.

We could find no cause for her anemia other

than the parasites. Three stools were negative for occult blood.

The patient was discharged on continued Delvex and Iron. She was seen one month later at home and was doing well. Her hemoglobin was 9 gm. All her siblings had parasites and one had 4 gm. of Hb., another 7 gm. They were put on Iron and Delvex with the help of Dr. George Tootell of the Pine Mountain Settlement School and of the Frontier Nursing Service who followed through on therapy of the family.

One year later on 4/29/60, Dr. Tootell revisited the family. The child's hemoglobin was 9 and she was clinically well.

This child also may represent a kind of malabsorption due to worms but one cannot rule out chronic malnutrition. Her normal serum iron was baffling but we could not recheck it since she had been given blood after her first studies.

Summary

In conclusion it would seem that, with heavy infestations, intestinal parasites, namely Giardia, and some of the roundworms, can be a cause of the malabsorption syndrome. With newer techniques now available further study seems indicated to validate this assumption.

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Ileus of the Colon

Ileus involving primarily the large intestine is an infrequently described entity of clinical significance. The colon frequently becomes distended due to mechanical obstruction or to interference with the blood or nerve supply of the bowel, but dilatation of the large intestine can reach massive proportions in the absence of any evident local cause. This type of large bowel distention is reviewed and 8 cases reported. The etiology of the colonic ileus was not evident but an association with previous uterine surgery was noted in 3 and with infection somewhere outside the peritoneal cavity in 4 of the patients. Barium enema was an important aid in defining the problem. Despite the absence of organic obstruction, cecostomy for decompression of the colon was necessary in 4 of these patients to prevent or control perforation of the dilated bowel.

—J. H. Morton, S. I. Schwartz and R. Gramiak—Archives of Surgery (Sept.) 1960

Considerations In The Management Of Upper Gastrointestinal Bleeding

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I WOULD like to begin with a definition. By convention we will consider upper GI bleeding to be that from the gastrointestinal tract above the Ligament of Treitz. This is a physiological and anatomical separation. It is also one that has clinical importance since bleeding above this point is more likely to be brisk in the adult and to present with hematemesis. If the amount of bleeding is appreciable, the patient, especially if elderly, may present with symptoms relating to hypovolemia such as shock, myocardial ischemia, or a cerebrovascular episode rather than with the vomiting of blood or passage of a tarry stool. This discussion wil be limited to the situation in which a person has brisk gastrointestinal bleeding that is fairly obvious and at a rapid rate with tarry stools and usually with hematemesis.

General Principles

Some general principles can serve well in the initial consideration of the patient. Bleeding means that there has been erosion, either localized or diffuse, in the upper gastrointestinal tract. This may be superficial or deeper into a vein or an arterial vessel. As noted, with upper gastrointestinal bleeding there is more likely the jejunum, ileum, or the large bowel. If the bleeding is slow, there may be only melena while if it is brisk, there is much more likely to be vomiting of blood. If the vomitus is light pink in color, we can usually infer that the source is arterial but the converse does not hold true.

It is of major importance to establish a precise diagnosis. Treatment, of course, will vary with the cause and the site of bleeding. Inferences can be helpful but they may also be hazardous without the establishment of as definitive a diagnosis as possible. Further, the lesion that is found may not be the lesion causing the bleeding. For example, it is known that many cirrhotics bleed from ulcers or gastritis as well as from varices; turning it around the other way, many people with ulcers may bleed from gastritis or from esophagitis. This dilemma has been phrased very well by Dr. Eddy Palmer[1] who pointed out that patients with bleeding who were known to have a potential bleeding site were bleeding from that previously established potential bleeding site only half of the time; in the other half they were bleeding from some other condition.

Diagnostic Possibilities

An approach to the management of the patient can be facilitated by considering the diagnostic possibilities. It is difficult to draw inferences as to the percentage likelihood of a given lesion causing upper gastrointestinal bleeding in a particular patient since the reported series vary in a number of important respects. They vary in the time at which the series was collected, in the time between the episode of bleeding and the performance of diagnostic studies, and in the type of diagnostic studies which were performed.

This is of importance because many lesions may heal very quickly. Among these are gastritis, esophagitis, and the ulcer which fills in

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quickly. Further, it is necessary to have direct vision to confirm or exclude the presence of some lesions. Examples of these are esophagitis or gastritis and probably also varices.[2,3] Further, there is often a lack of parallelism between the order of causes of gastrointestinal bleeding found at autopsy and in clinical practice.[3]

It is of particular importance, then, to consider the likelihood that different lesions may cause upper gastrointestinal bleeding in a series of patients who have been studied very carefully by a vigorous diagnostic approach. By this I am referring to the approach formulated and propounded most vigorously by Dr. Eddy Palmer[1] and favored by an increasing number of authors.[4,5,6] This involves general support for the patient, ice water lavage of the stomach through a large caliber tube to control bleeding, and then esophagoscopy, gastroscopy, and emergency upper gastrointestinal x-rays with palpation.

Table I presents a series of 240 patients reported by Palmer.[1] These patients were studied by the vigorous diagnostic approach just outlined. Duodenal ulcer accounted for 22 per cent

TABLE I

Palmer	240 Patients
Duodenal Ulcer	22%
Erosive Gastritis	16%
Gastric Ulcer	13%
Esophageal Varices	12%
Esophagitis	8%
Hitatus Hernia, From Stomach	5%
Mallory-Weiss Syndrome	5%
Gastric Varices	3%
Rendu-Osler-Weber Disease	2%
Not Determined With Assurance	12%

of the patients' problems. Gastritis accounted for 16%, gastric ulcer for 13% esophageal varices for 12%, esophagitis for 8%, bleeding from the stomach with hiatus hernia for 5%, the Mallory-Weiss syndrome (a tear at the stomach just adjacent to the entry of the esophagus) for 5%, gastric varices for 5%, and Rendu-Osler-Weber disease for 2%.

There is a group of 12% in whom the diagnosis could not be established with certainty even with this thorough diagnostic approach. This experience contrasts somewhat with the frequent statement that peptic ulcer will account for 75 to 85 per cent of upper gastrointestinal bleeding. However, other series have been reported with similar diagnostic approaches and similar percentages.[5, 7] Spinal attention should be given to the importance of gastritis, varices, and esophagitis as causes for bleeding.

The second table outlines a method of approach to the management of the patient who is bleeding briskly from the upper gastrointestinal tract. First, we have the problems of resuscitation which I think are familiar to all of us. When the patient is bleeding rapidly, transfusions should be given at such a rate as to stabilize and maintain a circulating blood volume as near normal as possible.

TABLE II

Method of Approach

1. Resuscitate
2. Estimate Severity of Bleeding
3. Evaluate General Condition
4. Locate the Source
5. Use Medical Surgical Team
6. Plan Specifics of Management

The second problem is to estimate the severity of the bleeding. If the patient is vomiting copiously or if he is having several tarry bowel movements, there is clear evidence that massive bleeding is going on. Clinical judgment based on the patient's general state, pulse, blood pressure and the amount of external evidence of bleeding should be supplemented with serial determinations of hemoglobin, hematocrit and red cell count. If the situation is desperate and facilities are available, estimates of red cell mass can be a guide to transfusion therapy.

The next step is the basic one of evaluating the total situation. This involves calling upon as much historical information as possible, particularly old clinical records and x-rays or evidence of upper intestinal or lower gastrointestinal complaints in the past. The routine laboratory studies which are recommended may vary considerably. A red blood count, hemoglobin and hematocrit, urinalysis and a urea or non protein nitrogen are certainly indicated. If there is anything to suggest a blood dyscrasia, bleeding and clotting times and prothrombin time measurement are in order. The determination of the bromsulfothalein retention is especially useful in detecting cirrhosis and suggesting varices as a cause of bleeding. It is a worthwhile routine procedure in most patients with upper GI bleeding. Blood ammonia

concentration is definitely useful in this regard when available.[8]

The next point is to locate the source of bleeding. This is really of critical importance and deserves a great deal of emphasis. I mentioned before that the disease we find may not necessarily be the source of the bleeding.

Statistical probability offers some good but not entirely reliable guides as to the potential site of the patient's bleeding when coupled with review of the history, any past records, the physical examination, and the basic laboratory work. Scott[6] last year reported an important study outlined in Table III. 85 patients with serious upper gastrointestinal bleeding were studied. The basic evaluation of patients was of the type just outlined. When it was completed, the physicians indicated their best judgment of the site of his bleeding. Following this, the vigorous diagnostic approach was used and on that basis a final diagnosis established.

TABLE III

Scott (6)	85 Patients
Initial Diagnosis Correct	48—(56%)
Initial Diagnosis Incorrect	25—(29%)
No Definite Source Found	12—(14%)

In the 25 Wrong Diagnoses Therapy Would Have Been Harmful In 11 (12.9% Of Total)

The initial diagnosis was correct in 48 instances, 56% of the total. The initial diagnosis was incorrect 25 times, 29% of the total. No definite source was found in 14%. If the 25 incorrect diagnoses were considered, it was apparent that in 11 of these, or about 13% of the total group, therapy directed at the working diagnosis would have been harmful to the patient.

The next point to be emphasized is the importance of managing such patients from the outset with combined medical and surgical judgment with the surgeon, the internist and the medical team in consultation throughout the patient's course.

The sixth point is to plan the specifics of management. This will vary with the illness, of course. Certain generalities are important though. As noted, the basic requirement after resuscitation is to have available the best combined medical and surgical judgment. The decision about management of the patient relative to medical or surgical intervention will be influenced by the cause of his illness, the availability of blood, the skill of his staff, and the amount of staff available. So for example, if blood is in short supply and the staff is limited, there might be a relatively greater indication for surgical intervention.

The factors that favor surgery are under continuing study.[4,5,7,9,10,11,12] These will be reviewed briefly. Table IV outlines them.

TABLE IV

Relative Indications For Surgery

1. Uncontrolled bleeding with excessive blood replacement needs.
2. Bleeding over 24 - 48 hours.
3. Reappearance of bleeding.
4. Previous massive bleeding.
5. Age over 50 or evidence of arteriosclerosis.
6. Stenosed duodenal ulcer.
7. Need to identify source.

If the patient has uncontrolled bleeding with excessive blood replacement needs, we have a relative indication for early surgery. This describes the patient who is bleeding profusely, who requires 1500 to 2500 ccs of blood initially to stablize his condition and who then continues to bleed at such a rate that he requires more than a pint of blood per six hours to maintain stable vital signs.

A second factor favoring surgery early is prolonged bleeding, not controlled by medical management. A third is the reappearance of bleeding after it has apparently been checked. A fourth is a history of previous massive upper gastrointestinal bleeding. A fifth is age over 50 or the presence of arteriosclerosis. A sixth is obstruction with duodenal ulcer. A seventh is a need to identify the source in the face of continued bleeding and in the absence of an ability to identify a source with the vigorous diagnostic approach.

Only a few general comments will be made on the more important groups of specific causes for upper gastrointestinal bleeding. The largest category is gastroduodenal bleeding in which the most likely possibilities are peptic ulcer, benign or malignant, and gastritis. In considering management, it is again difficult to compare results because these will vary not only with the specific type of bleeding but also with the age of the patient, the associated conditions which patients have, and perhaps the skill of different teams. In general, the discussion up to this point has offered some guides

for choosing between medical and surgical management.

Dr. Karlson's group[9] at the Downstate Medical Center in Brooklyn treated patients who presented with gastroduodenal bleeding in such a way as to permit comparison between three possible methods of treatment. (Table V) One was to treat patients medically with sedatives and antispasmodics, frequent small feedings, and frequent small transfusions—the Andersen regimen. The second was to prepare the patient quickly and subject him to subtotal gastrectomy. The third alternative was selective

TABLE V

Karlson (9) 130 Patients

	N	Deaths	%
Nonoperative	58	8	14
Immediate Operation	37	5	14
Selective Operation	35	5	14
Total	130	18	14

operation utilizing the type of criteria mentioned before in order to identify those patients who required surgery.

As you will note, the nonoperative group had a 14% mortality, those subject to immediate surgery had a 14% mortality, and those subject to surgery on the basis of selection for operation also had a 14% mortality rate.

One can make a number of observations about this particular series, but several points stand out. First, the patients who died in the nonoperative, or medical, group died primarily from exsanguination. The deaths in the surgical group resulted largely from complications of the surgery. This points out the very real need for close coordination of the medical-surgical team to select as well as possible those patients who need surgery and then to select as well as possible the operation which is required for the individual patient.

Gastritis represents an important subdivision of patients with upper gastrointestinal bleeding. Dr. Palmer[13] has, to my knowledge, the most extensive experiences in the management of this problem. He has found the ice water lavage, mentioned earlier, to be effective in controlling bleeding in the great majority of patients. Results with these have been so effective in his hands as to make ice water lavage the first choice in management of this problem.

The whole question of varices is a very complicated one; time does not permit going into it in any detail today. In the initial approach to the patient the utilization of esophageal tamponade with the Blakemore-Sengstaken tube offers a good method of controlling bleeding initially after which one can go ahead and evaluate the patient further for any additional therapy which may be in order.

Summary

In summary, a method for approaching the management of the patient with massive upper gastrointestinal hemorrhage has been outlined. The importance of locating the source of bleeding and establishing a precise diagnosis by using a vigorous investigative program has been reviewed. The value of surgical and medical collaboration in caring for such patients is stressed.

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The Proctologic Aspect Of Bleeding From The Lower Bowel

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BLEEDING is a common sign of rectal trouble and one which should not be disregarded without a thorough evaluation. Seventy per cent of the usual causes of bleeding can be identified by visualization with the proctosigmoidoscope. A properly executed and satisfactory proctosigmoidoscopic examination will disclose the presence of neoplasms, that is, cancers and polyps, as well as other conditions such as chronic ulcerative colitis and various other non-malignant lesions which cause bleeding from the lower bowel.

Two Positions

Proper positioning and preparation of the patient is essential to a satisfactory examination. A table upon which the patient can be inverted is desirable but not absolutely necessary. A satisfactory examination can be done with the patient in the knee-chest or the left Sims position. The latter is often necessary when the patient is physically handicapped for one reason or another. One or two small plain water enemas are usually sufficient to wash out that portion of the bowel which can be visualized with the proctosigmoidoscope. There are, however, various packaged materials in disposable containers which serve a useful purpose in this regard when administered in the office prior to the anticipated proctoscopic examination.

Bleeding is perhaps the most important indication for a proctoscopic examination. Patients will usually seek advice because of bleeding, especially if it is associated with painful bowel movements. Proctoscopic examination is indicated whenever there are symptoms relative to the lower bowel such as bleeding, pain, constipation with or without diarrhea or when an abnormal or pathological process is palpated on digital examination of the rectum. In this instance, it should be mentioned that when a tumor can be palpated digitally, it is better to do the initial anoscopic or proctoscopic examination without preparation. It is a grave mistake to attempt to do a barium enema with such findings on digital examination without having previously visualized the lesion.

A proctoscopic examination should be a part of the annual routine physical examination of members of the older age group for the detection and possible eradication of cancer, and as a diagnostic procedure when certain subjective or objective findings are present, especially when the symptoms of pain, blood or diarrhea are to be evaluated. Usually stool examination, proctoscopic and roentgenologic studies should be carried out in that sequence, and the nature of the findings will determine whether or not all tests are indicated. An indication for roentgenologic examination is ordinarily an indication for a proctoscopic examination which should always precede the barium enema.

Anal Fissures

The most common cause of bleeding per ano is a break in the continuity of the anal skin, such as occurs in abrasions, fissures or various types of malignant or inflammatory ulcers. An anal fissure is probably the most common cause of the passage of blood from the lower bowel; likewise, it is the most common cause of pain in the region of the anus when associated with bowel movements. In the presence of such inflammatory or malignant ulcers the associated muscle spasm may render any examination very unsatisfactory and

perhaps impossible. It has been my experience that the application of 5% Xylocaine ointment to the area before attempting to make the examination will give satisfactory anesthesia within five to ten minutes after application.

The color of blood, about which much is said and much is written, discloses only presumptive evidence and should never be relied upon alone to make a preoperative diagnosis. The color of blood is determined by the length of time it has remained in the bowel. Its presence is more important than its color, and every practical effort to determine its source should be utilized if an accurate diagnosis is to be made.

Sources of Transanal Bleeding

As a source of transanal bleeding, hemorrhoids, especially internal hemorrhoids with or without ulceration, are almost as commonly found as fissures. Squamous cell carcinoma should be mentioned as it is found in the same anatomical location as the above mentioned lesions. However, it is by no means a common source of bleeding from the anorectal area, although bleeding from such lesions will be present at some stage in its natural history.

TUMORS OF THE DISTAL BOWEL: Adenomatous polyps, the papilliferous adenomas (villous tumors) and carcinomas follow in about that sequence as the cause of bleeding. The differential diagnosis of the aforementioned neoplasms is usually not difficult for one with any experience in proctosigmoidoscopy. A specimen for biopsy must always be taken from a tumor if the diagnosis is not obvious, and in any case in which radical surgery is indicated a specimen for biopsy is mandatory. Anticoagulant therapy is mentioned in this relationship because of its tendency to allow tumors of the distal bowel to bleed earlier than they might otherwise. One should never take bleeding for granted just because the patient is on anticoagulant therapy.

DIVERTICULOSIS: It is thought by most authorities that diverticulosis is the source of bleeding in patients with diverticular disease rather than the associated diverticulitis. In this disease, bleeding is usually from the right and transverse segments of the colon rather than from the descending and sigmoid portion of the colon, where inflammation is present. It is understandable that the thickened, fibrotic wall of an area of diverticulitis is less likely to bleed than the segment involved with diverticulosis without inflammation. The author has observed blood to well up in a diverticulum which could be made to evert into the lumen of the bowel. In fact the tragedy of cutting a section for biopsy was only narrowly escaped on one occasion.

An everted diverticulum closely resembles a polyp and especially the stalk of a polyp which has been broken off. Diverticula of the colon are present in 50% of persons more than 50 years of age. They are often identified by proctosigmoidoscopy when their presence has not been demonstrated by x-ray examination after barium enema.

CHRONIC ULCERATIVE COLITIS: This is a dangerous and treacherous disease, especially in the young. Its seriousness is much less if it develops after middle life. There are probably two types. The proctologist rarely sees the segmental type which usually involves the upper colon and the distal ileum. He is more familiar with the much more common type of chronic ulcerative colitis which begins in the lower rectum and progresses cephalad by stages of involvement of the mucous membrane. The process involves the entire circumference of the lumen of the bowel. It progresses finally to produce a thick, indurated, fibrotic bowel wall. The entire colon becomes shortened, and the typical "lead-pipe" appearance, so often seen by roentgenologic examination, is the end result.

DYSENTERY: Most important from the standpoint of this discussion is that caused by amebiasis. In the intestinal form of the disease, symptoms are caused by trophozoites and diagnosis is not difficult with the proctosigmoidoscope. Characteristic ulcers occur which can readily be differentiated from other ulcerative lesions by their characteristic elevated, reddened appearance. They measure 3 to 5 mm. in diameter and often exhibit a small abscess in the center of the polypoid area. The intervening mucous membrane is normal. The typical amebic ulcer is virtually diagnostic. Diagnosis is easily confirmed by immediate

microscopic study of material aspirated from an ulcer.

RADIATION PROCTITIS: This condition is produced by injury to the mucous membrane during the course of radiation to pelvis or abdomen. The blood is usually retained in the rectum for a time and the color is variable, and often dark (old blood, so to speak). Colostomy is of no benefit. In fact, it can be a liability, except in cases of obstruction which may be produced by fibrosis, edema and contracture of the bowel wall due to radiation injury. Diversion of the fecal stream will only encourage the production of obstruction by these processes.

INTESTINAL APOPLEXY: This process is impossible to diagnose accurately except by direct vision. It is not often that one is fortunate enough to visualize the rupture of an artery in the mucous membrane of the bowel. Of course, this diagnosis can be made only in that portion of the bowel which lends itself to direct visualization by proctosigmoidoscopy.

CONCLUSION: Proctoscopy is not a difficult procedure. Proficiency in its use by physicians called upon to do general or so-called "thorough examinations" is the only known method at present by which cancer of the rectum and distal sigmoid can be detected, controlled and eradicated. The color of blood is of less importance than its presence. Whenever it is present, all of the facilities available should be employed to determine its source.

Gastroenterostomy and Pyloroplasty After Vagotomy

Histamine dihydrochloride suspended in beeswax served as an ulcerogenic stimulant and was injected into 3 groups of dogs (1 mg/lb, for 28 days). Five of 10 control dogs developed peptic ulcers and 4 of 10 dogs with a previous pyloroplasty also showed ulcers at autopsy. Twelve animals who received the same treatment after recovering from vagotomy-pyloroplasty remained free of ulcers. Nine dogs of this group were converted into vagotomy-gastrojejunostomy and received, after complete recovery, another identical course of histamine injections. All animals developed ulcers. The duodenal loops of 3 dogs with Heidenhain pouches and gastrojejunostomy were perfused with 1/10 n NaOH. This resulted in a marked rise in a hydrochloric acid secretion from the pouches. Lack of duodenal inhibition is offered as a possible explanation for the high incidence of junctional ulcers after gastrojejunostomy.

—H. W. Heupel and L. J. Hay—Archives of Surgery (Sept.) 1960

Bile Pigment Metabolism In The Differential Diagnosis Of Jaundice

MATTHEW DARNELL, PH. D., M.D.

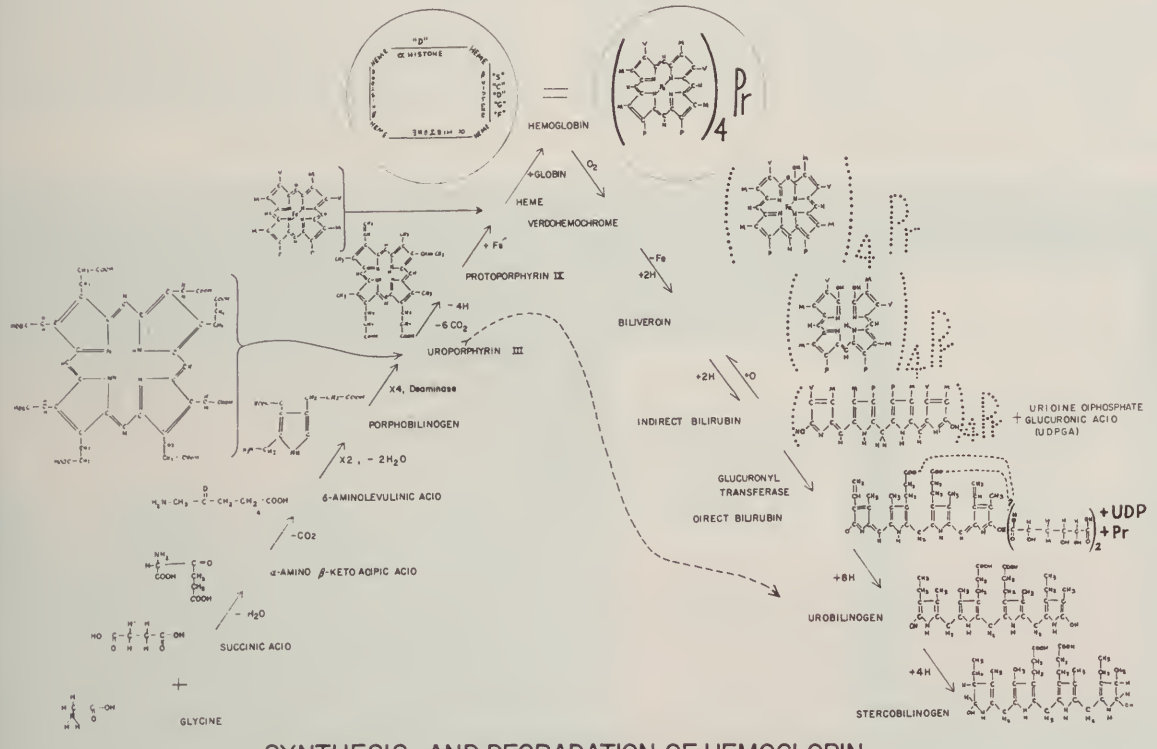
Lexington, Ky.

JAUNDICE IS the accumulation of bilirubin in serum and tissues in concentrations above normal. The detection of jaundice as opposed to yellowness depends on the chemical identification of bilirubin, and the measurement of amounts greater than normal depends on knowledge of what is normal. This in turn is more easily understood if the metabolism of bilirubin is considered.

The bile pigments (Figure I) are formed from the degradation of heme from worn-out red cells. Heme is a compound ring (wheels within wheels) combined with protein to form hemoglobin. In the reticulo endothelial system the compound ring is opened and iron is removed to form biliverdin. This protein-bound green substance is then reduced to the yellow substance, bilirubin, which is still bound to protein. Oxidation of yellow bilirubin, which occurs in tissues in longstanding jaundice, produces the green pigment again. This is thought to account for the green tinge of prolonged icterus.

The most useful chemical reaction for identification of bilirubin consists of the van den Bergh reaction, coupling bilirubin to diazotized

Figure I



SYNTHESIS AND DEGRADATION OF HEMOGLOBIN



attains
sustains
retains

extra
antibiotic
activity

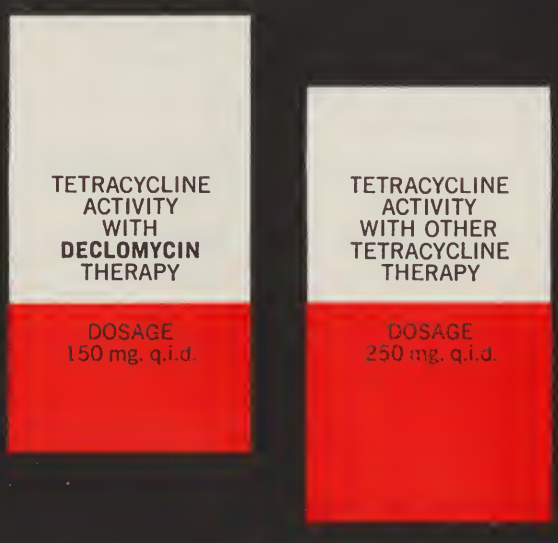
DEC

attains activity levels promptly

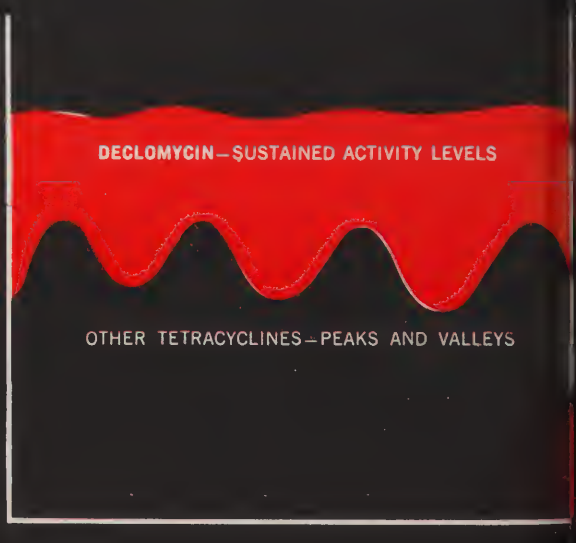
DECLOMYCIN Demethylchlortetracycline attains—usually within two hours—blood levels more than adequate to suppress susceptible pathogens—on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. The average, effective, adult daily dose of other tetracyclines is 1 Gm. With DECLOMYCIN, it is only 600 mg.

sustains activity levels evenly

DECLOMYCIN Demethylchlortetracycline susta through the entire therapeutic course, the high ac ity levels needed to control the primary infection to check secondary infection at the original—o another—site. This combined action is usually s tained without the pronounced hour-to-hour, dose dose, peak-and-valley fluctuations which cha terize other tetracyclines.



POSITIVE ANTIBACTERIAL ACTION



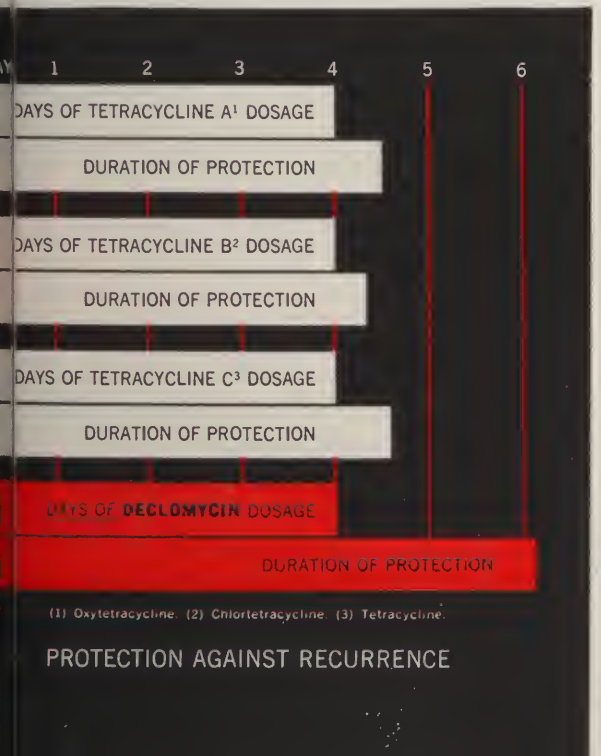
PROTECTION AGAINST PROBLEM PATHOGENS

LOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

tains activity
vels 24-48 hrs.

ELOMYCIN Demethylchlortetracycline retains ac-v/ levels up to 48 hours after the last dose is iv̇n. At least a full, extra day of positive action may ni be confidently expected. The average, daily adult oıge for the average infection—1 capsule q.i.d.—ıe same as with other tetracyclines...but **total** oıge is lower and duration of action is longer.



CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

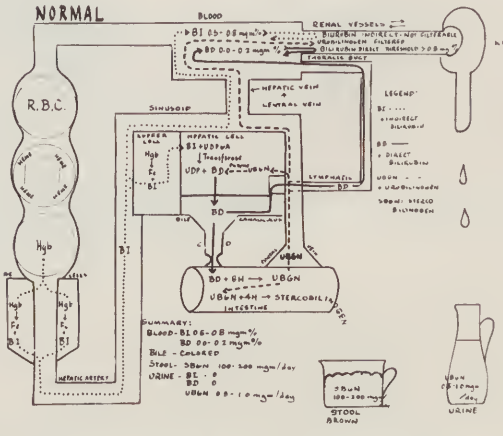
Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

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sulfanilic acid to form a red color. Van den Bergh found that this reaction proceeded rapidly in many jaundiced sera. They were said to contain direct-reacting or direct bilirubin. Other equally yellow sera were found to produce the pink color only after pre-treatment with alcohol. They were said to contain indirect bilirubin. It has long been supposed that indirect bilirubin is a protein-bound compound manufactured by the reticulo-endothelial system, and that this protein must be removed before the van den Bergh reaction will proceed.

Figure II



Recently it has been shown that normal liver cells contain enzymes called transferases which conjugate one or both acid side chains of bilirubin with glucuronic acid supplied by a high energy phosphate compound uridyl diphosphate glucuronic acid, or UDPGA.

The conjugation of both acid chains of bilirubin appears to be necessary for the transfer of bilirubin across the hepatic cell membrane into bile. In classical obstructive jaundice the "direct bilirubin" appears to be mostly doubly conjugated. In liver disease the direct bilirubin appears chiefly to be conjugated by only one acid group. Whether this is due to deficiency of enzyme in the liver cell or due to the leaking of the enzyme into the blood stream with conjugation there is not known with certainty.

Bilirubin is further reduced in the intestine to urobilinogen and stercobilinogen, in which form the heme of destroyed red cells is ultimately excreted.

Figure II shows the normal sites of hemoglobin degradation. Hemoglobin from worn-out red cells is converted to indirect bilirubin in the extrahepatic reticulo endothelial tissues and in the Kupffer cells of the liver. Most of it is passed on to the hepatic cell. Some circulates in the blood. Indirect bilirubin is not excreted by the kidney.

In the hepatic cell, bilirubin is conjugated with glucuronic acid and passed into the bile. Normally a small amount of this direct bilirubin may be absorbed into the lymphatics and carried to the systemic circulation via the thoracic duct. Its concentration in normal serum is below its renal threshold, so that none is excreted in the urine.

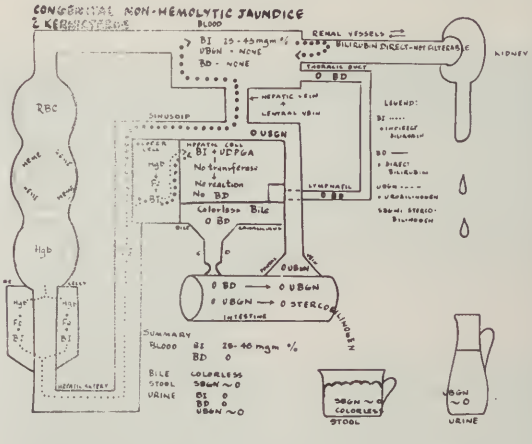
The bilirubin of bile is reduced by intestinal bacteria to urobilinogen. Some is absorbed by the portal circulation. This is carried past the hepatic cell, where most is metabolized (perhaps by unknown enzymes, back to bilirubin) and re-excreted. The balance of the urobilinogen is carried through the sinusoids to the hepatic vein and excreted by the kidney.

Most of the intestinal urobilinogen is further reduced to stercobilinogen and excreted in the stool.

Normally, then, blood contains indirect bilirubin in concentrations of 0.5-0.8mgm/100 cc. Blood may contain direct bilirubin in concentrations up to 0.2 mgm/100 cc.

Urine contains no bile, and about 0.5 - 1.0 mgm. of urobilinogen per 24 hours.

Figure III



About 100 - 200 mgm. of stercobilinogen is excreted in the stool in 24 hours.

To further illustrate the pathways of bile pigment metabolism, let us consider an entity called Congenital Non-hemolytic Jaundice with Kernicterus. (Figure III) The red cells are nor-

mal, and a normal amount of indirect bilirubin is produced from aging red cells. However, due to the absence of transferase in hepatic cells, no direct bilirubin is formed. Indirect bilirubin accumulates in serum to levels of 25 to 50 mgm. per 100 cc., sufficient to cause kernicterus. This indirect bilirubin is not excreted by the kidney. The bile is colorless and contains no bilirubin. No urobilinogen is formed or excreted. The stool is clay colored, not as a result of obstruction but due to absence of stercobilinogen. This is "alcholuric" jaundice, which is neither hemolytic nor pre-hepatic.

Massive hemolysis may take place as a result of (1) defective construction of hemoglobin, as in sickle cell anemia; (2) defective construction of the envelope as in primaquine sensitivity; or (3) acquired immunochemical accidents to the envelope as in transfusion reactions. (Fig. IV) The action of the reticuloendothelial system will produce large quantities of indirect bilirubin. If the amount of hemolysis exceeds the 50-fold reserve of the liver to conjugate bilirubin, some of this indirect bilirubin will not be removed and will accumulate in serum, causing alcholuric jaundice.

Figures for Hemolytic Types

The anemia resulting from the hemolysis may also impair the conjugating function of the hepatic cell. Large amounts of direct bilirubin will be put into the bile. A somewhat larger-than-normal amount of direct bilirubin, insufficient to exceed the renal threshold, will find its way into the lymphatics and the blood stream. Large quantities of urobilinogen will be absorbed in the portal circulation and excreted in the urine. Large amounts of stercobilogen will be excreted in the stool. Representative figures for the hemolytic type of jaundice might be given as:
Blood: BI* 5 mgm.

BD** 0.8 mgm.
Urine: BI O; BD O; Ubgen*** 5-30 mgm.
Stool: SBGN**** 600-2000 mgm/day
*BI - Indirect Bilirubin
**BD - Direct Bilirubin
***Ubgen - Urobilinogen
****SBGN - Stercobilinogen

Figure V illustrates the findings in common bile duct obstruction. The amount of indirect bilirubin carried to the hepatic cell is normal. Early in the course, all the indirect bilirubin is accepted by the hepatic cell from the Kupfer cell. Later, as the level of indirect bilirubin rises to about 3 mgm. per 100 cc., the hepatic cell can no longer accept all the indirect bilirubin from the Kupfer cell, and the level of indirect bilirubin rises. In the course of time, en-

Figure IV

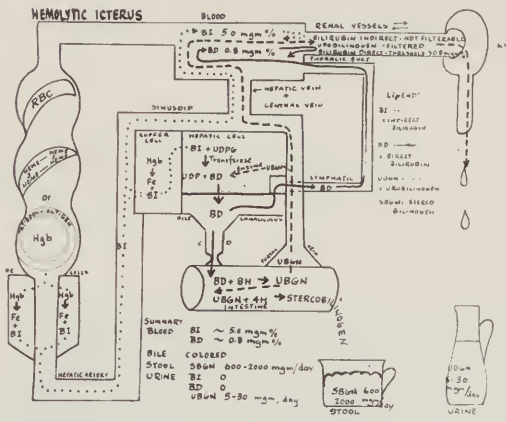
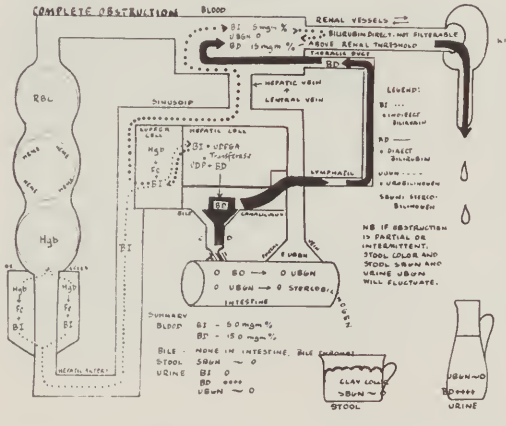


Figure V



suing liver cell damage may contribute to lack of conjugation.

The completely (diglucuronide) conjugated bilirubin is passed into the biliary canaliculi. Since the outflow of bile is impeded, bilirubin leaks through the canalicular walls, to be taken up by the lymphatics. The level of direct bilirubin in the blood is elevated to a level above the renal threshold for direct bilirubin and this substance then "spills over", into the urine. Since little or no bile gets into the intestine, no urobilinogen will be formed and none will be excreted in the urine.

If the obstruction is intermittent, the urobili-

nogenuria will fluctuate. If we consider that the tissue of the intestinal wall is jaundiced, we can explain slight urobilinogenuria as a surface reduction of the bilirubin of the intestinal wall. The color and stercobilinogen content of the stool will depend on the completeness of obstruction.

Representative figures for the findings in complete obstruction are:*

Blood:	BI	5.0
	BD	15.0
Bile:	None in duodenum	
Urine:	Bile	++++
	Ubgen	none
Stool:	SBGN	none

*Abbreviations as before

It might be mentioned here that bile salts also leak into the lymphatics, find their way into the blood stream, and cause itching.

In hepatocellular disease, like hepatitis, there are at least three variables:

(1) Swelling of cells with obstruction of bile canaliculi. Direct bilirubin secreted into obstructed canaliculi enters the lymph and blood in amounts sufficient to spill into urine. (There is some thought that direct bilirubin may be the result of intravascular conjugation by leaked transferase.

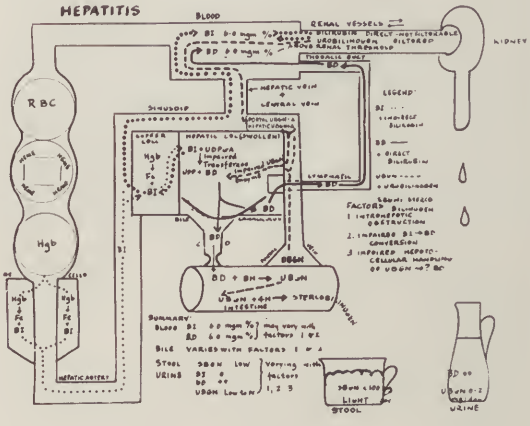
(2) Disorders of enzymatic conjugation of bilirubin, with incomplete (monoglucuronide) or absent conjugation of most of the bilirubin and accumulation of indirect bilirubin as the result.

(3) Disorders of hepatocellular urobilinogen reconversion and re-excretion, resulting in urinary excretion of larger than expected amounts of urobilinogen.

The findings in hepatocellular disease will depend on the interplay of these variables. (Figure VI)

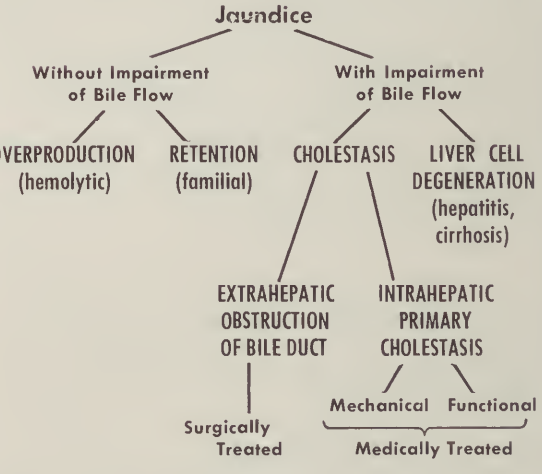
If we remember that bile in the urine means obstruction somewhere in the biliary system, either in the liver or past the liver; that the presence of urobilinogen in the urine implies the presence of bile in the intestine; and that abnormal accumulations of indirect bilirubin in blood implies either overwork of the RE system in hemolyzing or underwork of the liver in conjugating, we will have come a long way in classifying jaundice.

Figure VI



Without deprecating the usefulness of classification, it seems reasonable that understanding the physiology of the three substances—indirect bilirubin, direct bilirubin and urobilinogen—is less arduous than remembering the ten entities in the usual classification of jaundice such as that proposed by Popper (Figure VII).

Figure VII



Types of jaundice. Overproduction, retention, cholestasis, and liver cell degeneration are entities that can be differentiated by laboratory tests. (Popper, H., and Schaffner, F.: J.A.M.A. 150:1367, 1952.)

Roentgenographic Considerations In The Differential Diagnosis Of Jaundice

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Lexington, Ky.

THE CONTRIBUTION of radiology to the differential diagnosis of jaundice has suffered somewhat from the twin evils of over and underestimation of its value. Like any diagnostic modality it must be used with discrimination and a perception of its limitations. However, if the clinical situation is selected wisely, information of distinct value will be obtained in the delineation of the pathogenesis of difficult cases of jaundice.

The roentgenographic approach to the diagnosis of the patient with jaundice should start with the simplest procedure. Consideration should therefore be given to an ordinary flat film of the abdomen as a first step. On occasion, a tumor mass can be outlined in the upper abdomen which will confirm the clinical impression derived from careful palpation preceding the x-ray study. At other times, special features of the mass, such as calcification, may be of aid in suggesting the specific nature of the tumor. For example, almost all primary carcinomas of the gallbladder are associated with gallstones. The majority of these contain sufficient calcium to be visible on a simple flat film of the abdomen.

The most frequent positive finding of value on a plain scout film is calcified gallstones. Whenever visible stones are clustered together in the region of the gallbladder, the possibility exists that a nonopaque or obscured stone has separated itself from its fellows to become lodged in the common duct. This diagnosis can become a certainty and establish the cause of the jaundice when the common duct stone contains sufficient calcium to be visible. (Figure 1) As a matter of anatomical reference it is well to remember that the gallbladder, on most occasions, is closely approximated to the hepatic flexure of the colon which can usually be identified by gas within its lumen.

On rare occasions, the gallbladder may be visible by virtue of gas within its lumen and sometimes within its wall — so-called emphysema of the gallbladder[1]. (Figure 2) This results from severe cholecystitis due to gas-forming bacilli, particularly in diabetics or in association with biliary obstruction. In other infrequent instances, much of the biliary tree may be seen to contain air. (Figure 3) Generally speaking, this situation is occasioned by rupture of a gallstone through a severely infected gallbladder wall into the duodenum to which the gallbladder has become adherent, leaving a persistent cholecystoduodenal fistula through which the intestinal gas enters the biliary tract.



Figure 1
Arrow points toward stones in common duct.

*Chairman, Department of Radiology, University of Kentucky, College of Medicine, Lexington, Kentucny.



Figure 2 — Note fluid level in gallbladder on film shown at right.

Some gallstones, usually of the nonopaque cholesterol variety, may contain stellate fissures [2] originating near the centers of the stones. These fissures usually contain air and sometimes cast a characteristic shadow on a radiograph that can be identified even though the stone itself contains no calcium.

Considerable confusion exists as to the value, if any, of cholecystography and intravenous cholegraphy in the presence of jaundice. The truth of the matter is that these procedures may be of considerable value if properly employed and properly interpreted. Both oral and intravenous contrast studies of the gallbladder are, in a sense, tests of hepatic function, since the liver must be capable of excreting the opaque medium quite rapidly for it to accumulate in the biliary structures in sufficient concentration to be visible. This presumes adequate absorption of the oral opaque medium from the intestinal tract.

Nonvisualization is of no differential value since this result will obtain in a sizable percentage of patients regardless of the etiology of the jaundice. If the serum bilirubin is above 5.0 mgm.% these procedures are useless since virtually every case will fail to depict a gallbladder or bile ducts. This assumes, of course, that the jaundice is not hemolytic in origin. Visualization of the bile ducts, gallbladder or both may be expected in 1/5th to 2/3rd of cases with lesser degrees of jaundice.[3, 4] The lower the serum bilirubin the greater the likelihood of obtaining visualization of the biliary structures.

If the common duct is demonstrated, information as to etiology of the jaundice may be



Figure 3
Arrows point toward air in biliary radicals.

forthcoming. A common duct stone is the commonest positive finding, but obstructing tumors and metastatic nodes have been demonstrated in this manner. If the gallbladder is not visualized in the presence of a vivid common duct an obstructing stone safely may be assumed to be present in the cystic duct.

Wise and Twaddle[5] have shown that a common duct partially obstructed by a stone drains less rapidly than normal. Using a time-density-retention concept, they have demonstrated that a partially obstructed common duct will show an increase in density of total dye retention 120 minutes after injection when compared to a film taken 60 minutes after injection—the reverse of the normal situation. This can occur even though no stones are directly demonstrated.

A normal cholecystogram or cholangiogram is more common with intrahepatic than extrahepatic origins of jaundice. Normal findings occur more frequently in the presence of hepatitis than cirrhosis.[6] Administrations of paregoric may cause constriction of the sphincter of Oddi, particularly if pathology is present, and increase the percentage of cases with adequate visualization of the common duct following either ingestion or intravenous injection of opaque media.

Levene and Scheff[7] have described a lateral curving and displacement of the distal end of the common duct on cholangiography as typical of carcinoma of the head of the pancreas. I have no knowledge, however, of this characteristic appearance being demonstrated in the presence of jaundice.

The four-day Telepaque test of Salzman[8] may, upon occasions, be extremely useful in identifying common duct and intrahepatic calculi. Dr. Salzman and associates have amply demonstrated that, despite failure to demonstrate stones by more ordinary methods, biliary calculi may become visible by keeping the patient on a low-fat diet and administering 1 gram of Telepaque after each meal for four days with films being taken on the morning of the 5th day. (Figure 4) The stones become visible because Telepaque combines with biliverdin on the surface of the stone making it opaque. This reactions occurs in 20% of gallstones. Pigment must be present on the surface of the stone for this phenomenon to occur. Stones demonstrated in this way may be faintly outlined, but their presence may be of great



Figure 4 — Film at left before four-day Telepaque test. Film at right shows stones in both gallbladder and common duct (courtesy of E. Salzman, M.D.)

valuc in the diagnosis of difficult situations when jaundice is a presenting symptom.

An upper gastrointestinal examination may, in some instances, uncover an explanation for jaundice. Esophageal varices establish the presence of portal hypertension and strongly suggest cirrhosis. Positive findings arc found in perhaps 40% of carcinomas of the head of the pancreas (Figure 5). Some of the abnormalities secn with pancreatic neoplasms are deformity or displacement of the distal end of the stomach, erosion or displacemcnt of thc duodenal loop and perhaps even a filling defect within the duodcnal lumen.

A congenital choledochal cyst may present a fairly typical downward and medial displacement of the duodenal bulb and loop (Figure 6) which should immediately suggest thc diagnosis, particularly if the age of the patient, duration of the jaundice and other clinical information is consistent with this etiology.

Percutaneous splenoportography can provide valuable information as to the presence of cirrhosis and mass-occupying lesions, such as metastases, in the liver. This examination involves injection of an opaque medium directly into the substance of the spleen and exposing



Figure 5
Arrow points toward constant impression on medial aspect of second portion of duodenal loop.

films as the opaque agent passes through the portal system and hepatic substance. This procedure is not without its complications and should not be approached casually. Nevertheless, undcr appropriate circumstances, valuable



Figure 6 — Film at left shows displacement of duodenum. Film at right shows cyst at surgery filled with opaque medium.

and at times critical information can be obtained in this manner.

Summary

In the specific situations outlined in this paper, the radiologist can make a significant contribution to the study of a patient with jaundice. The proper use of the flat film of the abdomen, the discriminating use of the newer techniques for visualization of the gallbladder and biliary tree and the ancillary employment of the upper gastrointestinal examination will often clarify a difficult clinical situation. When this information is then placed into the clinical and laboratory context a more complete understanding of the patient's illness can be obtained and management can proceed more rationally.

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Inflammatory Polyps of Ileum and Cecum

Polyps composed of fibrous tissue disposed around and among blood vessels and infiltrated by inflammatory cells, predominantly eosinophils, have been reported in the stomach but not in the small intestine or colon, though similar lesions in these locations may have been called fibroma, angiofibroma, perithelioma, etc. Two cases of such inflammatory fibroid polyps, 1 of the ileum with intussusception, and 1 of the cecum with hemorrhage, have been observed. Both were successfully treated by surgical excision. The lesions appear to be inflammatory rather than neoplastic. They appear to be composed of granulation tissue of varying age and maturity and probably are sequelae of injury or irritation of the mucosa or submucosa of the gastrointestinal tract.

—H. J. McGee, Jr.—Archives of Pathology (Aug.) 1960

SPECIAL ARTICLES

Neighbors of Medicine In South America*

C. Dwight Townes, M.D., and Arthur H. Keeney, M.D.

CURRENT problems with foreign trained physicians in Kentucky, plus the unique opportunity to be guests of seven South American medical schools, make timely consideration of medical situations in these neighboring countries.

The world-wide warmth of medical fraternity, plus traditional hospitality of our South American neighbors, renders a visit to their centers a real "fiesta" of cordiality. They are superb hosts and completely open in discussing problems of medical education and practice.

The Pan American Association of Ophthalmology arranged visits as Alvaro Lecturers to Rio de Janeiro (Universidade de Brasil) and Sao Paulo (Escola Paulista, Universidade de Sao Paulo), Brazil; Montevideo (Universidad de Uruguay); Buenos Aires (Universidad de Buenos Aires), Argentina; Santiago (Universidad de Chile); Lima (Universidad Nacional Mayor de San Marcos), Peru; and Bogota (Universidad Javeriana and Universidad Nacional de Colombia), Colombia. In each city we also addressed their major ophthalmological society; twice they graciously extended official membership in their societies.

Effects of Socialization

These five weeks brought close the effects of socialization on medical education. In nearly all South American nations, there is complete socialization of medicine with concomitantly socialized schools, generally having no tuition charges. Curriculums are largely six or seven years, and students are accepted at a level approximating that of one year post high school training. Dedicated and distinguished leaders dot the South American schools, but inescapable evidences of commercialism, rank awareness, and feelings of "let the student get it if he can" are prevalent.

Governmental instability is frequently reflected by broad inconsistencies in monetary allowances to health and education services. Extreme government excesses were evident from the Peron decade in Argentina (1945-1955). Here, the appointment of variously qualified Peron favorites was responsible for suspension of such luminaries as the Nobel prize-winning Housey and the gallant dean of Ophthalmology, Professor Arganarez. Political action favoring less qualified candidates once brought the freshman medical class at University of Buenos Aires (the largest medical school in Argentina) to a level of 7,000 students. By gradual strengthening of entrance requirements, the freshman class in medicine has now been reduced to only 4,000. The faculty (in current difficulties attendant on "reconstruction") is cognizant of educational impossibilities with such huge numbers.

Though these capitals have multimillion populations (Rio, 2.9 million; Sao Paulo, 3.4; Buenos Aires, 3.7; Santiago, 1.6; Lima, 1.3 and Bogota, 1.0), out-patient clinic opportunities are inversely proportioned to student population. In many schools, students are not even scheduled to attend specialty departments in what we think of as "clinical" years. At times, physical entrance to lecture halls is achieved only by luck or good footwork.

From the student point of view, however, schools are "free" and matriculates usually continue at lectures and curriculum several years longer than the minimum period. They may repeat examinations in several subsequent years or partially drop out to assist or "practice" with some graduate physician. Internships are

*From the University of Louisville School of Medicine, Section on Ophthalmology.

served for a year on completion of strenuous theoretical and academic examination.

On the credit side, dictatorial governments have sporadically given bursts of huge material support to medical plants. The present 15-story basic science building of the University of Buenos Aires was built by the Evita Peron Foundation, and a 1200-bed teaching hospital immediately adjacent is still under construction. Unique trappings of governmental "rank" are seen in the medical library where an opulent reading room is reserved for full professors, a less luxurious room is marked for assistant professors, and the usual type of library reading room with long desks and chairs is provided for students.

In Bogota a partially completed and partially occupied government hospital is so huge that lesser staff workers ride bicycles through the corridors. An imposing, but not remarkably designed 18-story Hospital de Clinicas of the University of Uruguay has never been utilized in the upper nine stories.

Strong Unions

Strong student and intern unions, plus looming faculty unions, compound difficulties faced by administrators and ministers of health in making decisions on the ideal basis of what will produce best medicine for the individual sick patient. Aggressive student unions with regular publications are difficult for us to comprehend but apparently had useful origin years ago when professorial appointments were almost hereditary and held tightly by a few aristocratic families.

Initially the student unions helped the cause of skilled younger instructors who were essentially blocked from promotion. Today, they may serve as tools for individuals with political rather than academic design, and at times take seemingly inappropriate action as when Venezuelan students threatened bodily disruption of opening sessions of the Pan American Congress of Ophthalmology held in Caracas last February.

Postgraduate work is still largely by the system of apprenticeship and prolonged assistancies. Formal courses are largely embryos subsequent to World War II, and earnest residency programs as we know them in ophthalmology are essentially non-existent. This is somewhat more understandable on noting that regular ophthalmic teaching in the parent nations of Spain and Portugal did not evolve until the beginning of this century.

Long-standing faculty employment practices throughout South America strongly follow the leanings of Sir William Osler to the use of part-time men. Health budgets are top-heavy in nations with socialized medicine, and physician salaries are generally low, with the rationalization that part-time private practice is permitted.

There is also some real compensation of prestige from University posts. Most physicians devote half of each day to government agencies such as a medical school, social security hospital, municipal employees hospital, laborers hospital, etc. For physicians of established reputation this leaves half of the day for busy and lucrative consultation. Young physicians, however, as in England, find it often quite difficult to establish private work except as an assistant or under the direction of a senior colleague.

The almost exclusive pattern of part-time instructors is of value to the practical side of medical education, but is considerably responsible for the dearth of research activity in ophthalmology.

Though nesting in the heritage of many paradoxes, South American medical teachers and deans are awake to the changing needs of intensive educational practices. Chairmen of Eye Departments consistently outline substantial plans for training improvements that are in process of enactment.

The magnificently planned new medical school plant in Santiago is being securely built on a pay-as-you-go basis; here there will be excellent integration of basic sciences, teaching, research, and patient care. The small new Universidad Javeriana in Bogota, under its vigorous, 32-year-old dean of medicine, is creating a new concept in Colombian education with a geographic full-time faculty and many full-time department heads. Distinguished professors such as Housey have returned to teach in Buenos Aires. A Brazilian Council of Ophthalmology is acquiring, in that nation, the effect of our American Board of Ophthalmology here.

The failure this spring of 34 out of 47 foreign trained physicians in Louisville to pass the recently established qualifying test points up long-standing deficiencies. With understanding, cooperation and complete honesty between physicians of various nations, much can be achieved in altering this situation, and in turn to warm the cold tensions that now beset the world.

EDITORIALS

In Orbit

THE Medical School of the University of Kentucky began last month instruction of its first class of 40 students. This is a momentous occasion. Ours is the only new medical school in the United States placed in operation this year. It is with considerable pride that we claim it is built and equipped with the best and most up-to-date plans and materials available. The curriculum and mode of instruction has been developed on what is thought by medical leaders to be the very best in medical training for today.

The Medical School is the first unit in operation of the A. B. Chandler Medical Center of the University of Kentucky which will comprise also, when completed, School of Nursing, School of Dentistry, School for Medical Technologists with adequate teaching facilities and a 400-bed hospital for use very largely in the care of the indigent sick in our State.

The new Medical School now accepting a freshman class of 40 students is constructed for the instruction of 75 students in each class. It will probably be two or three years before a maximum enrollment is accepted. This year, however, for the first time in a generation as many as 135 freshman medical students are under instruction in Kentucky (95 freshman at the University of Louisville School of Medicine and 40 freshman at the University of Kentucky College of Medicine). In three or four years at the longest we may expect a total freshman medical class of 175 in the two universities.

Serious question has been raised whether a sufficient number of applicants for medical education from young men and women in Kentucky will be found to keep these schools operating at capacity so that the state may receive the maximum benefit from their expensive maintenance. It would in fact be a major calamity if it should turn out that this prediction is true. A fact of some importance bearing on this subject has come into being during the past year, the further increase of tuition for out-of-state students at the University of Louisville School of Medicine to a point that it is by many people deemed prohibitively high. This factor deprived the freshman class of the University of Louisville of at least one prospective student in the present year.

There are two things which we as Kentucky physicians can do and should do to keep these schools operating at full capacity with Kentucky youth. The first of these is an active recruitment of promising candidates of good scholarship. Heretofore, we have never been able to offer very much encouragement to boys to study medicine, because we have not had available sufficient opportunities for them to pursue their studies in our own educational institutions. Now that is changed. We can quite honestly encourage students to undertake the study of medicine with full confidence that if they attain the required level of scholarship and possess, in the estimation of our admissions committees, the other requisites necessary, there will be available an opportunity for them to continue the study of medicine in our State.

Many boys of higher scholastic possibilities are not able to continue their education because of the lack of financial resources. They may not even go beyond high school because they are not able to afford a college education. The economic hazard increases very appreciably with the prospect of entering medical school and every year there are men of good scholarship and a desire to study medicine

who are not able to do so because they cannot muster the necessary financial support.

We as physicians could do a very great deal in recruiting medical students and, if necessary, sponsoring or subsidizing through medical school and even through college, if necessary, worthy students. There are more than 2,500 physicians in Kentucky. It seems that of this number there should be 100 who would be willing to sponsor one student a year through medical school; that would be 25 students per year receiving such help from individuals. The KSMA's Rural Kentucky Medical Scholarship Fund is making tremendous strides in this area. In the past 10 years it has helped or is helping 201 students to finance their medical education. More scholarships are needed; more outright grants to students or long time loans while they pursue their medical study.

If such a willingness were expressed by any number of physicians or other persons, candidates could be very carefully selected from our colleges by the agency of the dean, registrar, or other person intimately acquainted with their circumstances. When there is found such a candidate for the study of medicine who lacks but financial support, he could be placed in touch with his sponsor and enabled to carry on his medical education.

What greater satisfaction can an aging physician find, when the time comes that he must diminish or cease his own professional activity, than to point to a young man newly educated and trained in medicine who is worthy to carry his mantle and to say "but for my aid this boy would still be behind the plow or at some more menial task less beneficial to mankind." What better service could he render the people of Kentucky?

Kentucky now stands very low in the number of physicians per population and in the adequacy of its medical care. Our increased facilities for educating medical students is now in operation. It must be run to capacity for our people to achieve the maximum benefits.

How many will join me in this worthy experiment in human welfare? How many will recruit and help to educate physicians in sufficient numbers to meet our crisis?

Sam A. Overstreet, M.D.

Let's Vote

IT has been claimed—I think with very little justification — that the members of the medical profession are particularly inert when it comes to exercising their franchise at the polls. Much ado has been made during the past few years about our participating in political and civic activities. We can do this in no more tangible or effective manner than to vote.

Certainly everyone of us has become reasonably acquainted during the past few months with the questions upon which balloting will be done this November. There are some decisions of great importance to be made pertaining to our local communties, to our state, and to the nation at large. We would be shortsighted should we fail to express our preference in these vital matters.

An additional civic service would be for us to insist upon the members of our families voting and likewise to encourage our office and technical assistants to exercise their franchise. We might even offer half holidays on election day to encourage our office force to go to the polls.

There are many trouble spots in the world, where democracy is being born, or is engaged in a struggle for existence. Ours is the most secure and complete democracy in all history. Let's keep it alive and growing.

Sam A. Overstreet, M.D.

Kentucky's New . . .

COLLEGE OF MEDICINE

University of Kentucky College of Medicine, first activated unit of the U. of K. Medical Center, opens its doors to an inaugural class of 40 students, 33 of whom are Kentuckians



MEDICAL SCIENCE BUILDING, a six-story, T-shaped structure, is the first functioning unit of the new U. of K. Medical Center.



SMALL STUDENT LAB—Demonstrating one of the 20 small student laboratories in the Medical Science Building is Robert M. Biltz, right, research chemist in the Department of Medicine. These laboratories are designed for permanent assignments, 16 students to each lab, mainly for the first two years of study. The students, from left, are: Martin Gebrow, Louisville; Troy Burchett, Stambaugh; Joe C. Christian, Lexington, and William Markesbery, Florence.

Center Dedicated



The U. K. Medical Center was dedicated in special ceremonies on September 23. Above is the architect's conception of how the buildings will look when completed late in 1961.



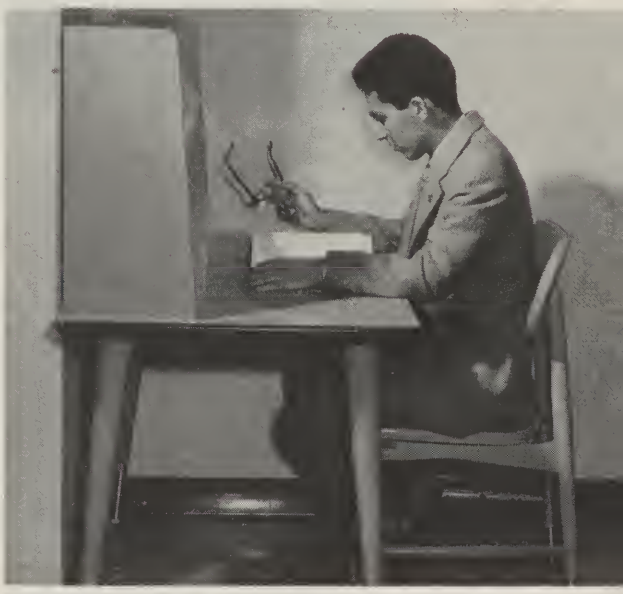
STUDENT STUDY CUBICLE—Each medical student entering the Medical Center is assigned an individual study cubicle. One of two general patterns is shown here—the open type designed more for group study. The other plan separates the cubicles and affords more privacy. From left are: Joe C. Christian, Troy Burchett and William Markesbery.



SMALL CLASSROOM—Robert E. McCafferty, M.D., assistant professor of anatomy, discusses a point with a group of medical students in one of the small classrooms of the Medical Science Building. Students will have the advantage of "small" group discussion and a seminar atmosphere. Back row, from left: Joe C. Christian, Lexington; Carl W. Watson, Lexington; Ballard D. Wright, Prestonsburg; Martin Gebrow, Louisville; Danny H. Kaufman, New York, N. Y.; Doctor McCafferty; Helmuth Scherer, Georgetown; Troy Burchett, Stambaugh; front row: Mallory T. Harling, Dayton, Ohio; S. Manuchehr Alavi, Tehran, Iran; James A. Cunningham, Lexington, and Claude H. Farley, Jr., Pikeville.



RURAL SCHOLARSHIP HOLDERS—Four recipients of Rural Kentucky Medical Scholarship Fund aid are interviewed by William H. Knisely, M.D., professor of anatomy and chairman of the scholarship committee of the University of Kentucky College of Medicine. The students are, from left, seated: Joseph R. Bowling, Jr., New Haven, and Helmuth Scherer, Georgetown; standing: James A. Cunningham, Lexington, and Ballard D. Wright, Prestonsburg.



INDIVIDUAL STUDY TABLE on the main floor of the library section is put into use by S. Manuchehr Alavi of Tehran, Iran, who received undergraduate training at Berea College. Other tables are provided in the library for group study. The library already has accumulated 50,000 volumes and subscribes to about 1,200 journals and periodicals.

THE University of Kentucky College of Medicine—first functioning unit of the imposing new $27,000,000 Medical Center on the Lexington campus—opened September 12, inaugurating a new concept in medical education and beginning what promises to be an exciting new chapter in Kentucky's 161-year-old medical history.

The inaugural class of 40 students, including one girl, represents the pick of more than 400 applicants. Of the 33 Kentuckians in the group, four are the recipients of KSMA Rural Kentucky Medical Scholarships. Eighteen members of the class are married.

On September 26 the College of Nursing admitted its first class of 30 students. Their first two years will be in academic work preparatory to clinical experience with patients in the Center's Teaching Hospital now under construction. Facilities for 400 beds in the hospital are planned in addition to a 100-bed ambulant wing; progressive patient treatment will be put into practice.

Also in the construction stage is the Dental Science Building which will house the College of Dentistry, scheduled to open in the fall of 1961. Initial enrollment will be 50.

Eventually the Center is expected to serve 1,200 full-time students, with a nucleus of 150 instructors,

according to William R. Willard, M.D., vice-president of the Center and dean of the College of Medicine.

Innovations

The Center's basic philosophy is expressed in a number of innovations giving special emphasis to behavioral science, community service, community medicine, and individual student study.

New in concept is the Department of Behavioral Science, covering primarily sociology, cultural anthropology, and social and experimental psychology. One of Community Services' major objectives is to aid in the improvement of the total health complex of Kentucky, and to this end the Center has opened its facilities to all groups and individuals in the health field. Meeting the health needs of the small towns and rural areas of the state has been emphasized by Doctor Willard as one of the most urgent purposes of the Center.

A third innovation is the Department of Community Medicine, established to help the student understand the problems of practice in a complex society or a rural setting.

The new approach to study is dramatized in the 150 study cubicles located on the first floor of the Medical Science Building. Each student is assigned one of these "thinking offices" the day he enters college, and it is open to him 24 hours a day. Each of the private niches contains a metal desk, locker and file cabinet enameled in soft yellow.

One Integrated Unit

When completed the Center will function as one integrated unit. To the six-story, T-shaped, red-brick-and-steel Medical Science Building will be connected the other two structures—the six-story, rectangular Dental Science Building and the eight-story, cross-shaped Teaching Hospital with additional ambulatory and out-patient wings. Thus the clinical functions will be closely related with functions in the basic sciences.

Target date for completion of all construction is December, 1961.

Functional Modern Design

The Medical Science Building is entirely functional and air conditioned throughout. Each wing has twin corridors, flanked by offices and classrooms on the outside and laboratories and offices in the inner block. Interior concrete-block walls and maze of overhead pipes are softened by coats of cobalt-blue, lemon-yellow and Indian-red paint. Laboratories gleam with new equipment.

The building was designed to place emphasis on small-group learning and establish close relationship between faculty and student. This is pointed up in 20 small laboratories, accommodating 16 students each, where the instructor comes to the student in a reversal of the usual teaching method. The idea behind the plan is to help the student see each phase of medicine as a part of the integrated whole.

A feature of unusual interest is a 150-seat lecture hall with its own observation room. When lights are off in the auditorium, students are able to watch the diagnosis of a patient through the one-way glass in the observatory. A sound system enables the students to hear the instructor. Such an arrangement lessens a patient's embarrassment although he is told in advance that he is being watched.



THE FUTURE of the new Medical Center is discussed by William R. Willard, M.D., left, its vice-president and dean, and Richard G. Elliott, M.D., Lexington, new president of the KSMA. The walnut model of the Center is loosely pegged together and is often used as a demonstration device by Doctor Willard in his talks about the progress and future plans for the buildings.

Ultra-Modern Library

The Medical Library contains some 50,000 volumes, subscribes to about 1,200 journals. Located on the ground floor, the stacks have their private stairway to the reading room above. In the stacks the books are arranged on turquois shelves against yellow walls. The library includes rooms for listening to high fidelity, medical tapes and records, projection rooms and microfilm facilities. "Periodical" shelves are arranged to provide small study areas. The shelves are movable, allowing storage of unbound numbers behind the current literature.

The building has facilities for making its own precision instruments in the research machine shop on the ground floor. There also are located the post office and animal quarters.

The first floor, in addition to the library reading room and study-cubicle area, is occupied by administrative offices, a spacious student lounge and the College of Nursing. Anatomy, surgery and nursing science laboratories are found on the second floor. Upper floors are devoted primarily to laboratory and classroom purposes and house the other departments.

The Curriculum

The design of the building is flexible to permit the curriculum to evolve gradually with experience and the development of new knowledge.



OBSERVATION ROOM—One feature of the Medical Science Building which has received considerable attention of medical educators is the one-way glass observation booth built into the lecture room on the sixth floor. Demonstrating the technique are Robert Straus, Ph.D., professor of medical sociology and chairman of the Behavioral Science Department, and Claude Farley, Jr., Pikeville, a member of the inaugural class. Students observing are, front row, from left: Joe C. Christian, Lexington, Martin Gebrow, Louisville; Troy Burchett, Stambaugh, and Danny H. Kaufman, New York; second row, Joseph R. Bowling, New Haven.

Extensive research is planned. Already. the Center has received over $500,000 in research awards.

The curriculum is the result of three years of study by the Medical Center staff, who visited more than half of the medical schools in the nation for observation. About 60 per cent of the freshman curriculum is devoted to teaching in separate disciplines, such as anatomy, physiology, biochemistry and behavioral sciences. The rest includes courses in human growth and development and study of the neurological and other body systems. An introduction to interpersonal relationships in clinical work, traditionally offered to upperclassmen, is another feature of the first-year program.

The tuition is $500 per academic year for residents of Kentucky; $950 for non-residents.

PG Medical Education

Once the school year is well under way, the Center will be actively involved in postgraduate medical education, Dean Willard announced. Director of the program is the assistant to the vice-president, James A. Halsted, M.D., who recently returned from Iran, where he was a Fullbright professor of medicine. There he was chairman of the department of medicine at the University of Shiraz and chief of medical service at a hospital in Shiraz.

A 30-Year Dream

A new medical school for Kentucky had been a dream for over 30 years, Back in the fall of 1928 the late Dr. Frank L. McVey, president of the Univer-

(Continued on Next Page)

Mission of Medical Center Hailed At Dedication

The new University of Kentucky Medical Center was hailed as an expression of faith in Kentucky's future by Governor Bert Combs at dedication ceremonies on Friday, September 23.

University President Frank G. Dickey pledged U. of K's efforts to make it "one of the finest medical centers in the nation." He said it means "teaching, research and service can be brought to people who have not had proper medical care previously."

William R. Willard, M.D., vice-president of the Center and dean of the College of Medicine, outlined the Center's six objectives:

1. To train more health-care personnel for Kentucky.
2. To provide more educational opportunities for Kentucky's youth.
3. To offer postgraduate medical education for people in all health fields.
4. To facilitate medical research.
5. To help provide medical care for the needy.
6. To give a better quality of medical care.

Under the Physicians Service Plan of the Center, all patients admitted will receive equal care irrespective of ability to pay or source of payment, Doctor Willard said.

Dedication of the medical library on Saturday, September 24, concluded the two-day program inaugurating the Center.

sity of Kentucky, asked one of his staff members, Dr. J. S. Chambers, head of the Department of Hygiene and Public Health, to make a study of the need of medical education in the state.

"The time will come," he said, "when we will need the data. We must be ready."

So it came to pass that Lexington, where the first medical school west of the Alleghenies was formed at the old Transylvania University in 1799, was chosen as the site for the new school.

Developing the Center

The story of the actual establishment of the Medical Center began on June 1, 1954, when the University of Kentucky board of trustees took action to establish a college of medicine "to be started when the General Assembly of the State of Kentucky provides the necessary funds." A subsequent resolution adopted on May 28, 1956, launched the program on its way. An initial appropriation of $5,000,000 was made by the General Assembly in 1956.

The site chosen was a 39-acre area on the Agricultural Experiment Station farm adjacent to the main university campus. Ground was broken for the Center on December 10, 1957.

Dean Willard arrived on the scene in July, 1956. Challenged by the once-in-a-lifetime opportunity to develop a medical center from the beginning, he left the post of dean of the Upstate Medical Center of the State University of New York at Syracuse to come to Kentucky.

Assisting him from the beginning have been four men: Robert Straus, Ph.D., chairman of behavioral sciences; Howard L. Bost, Ph.D., assistant vice-president for policy and planning; Allen Ross, M.D., medical statistician, and Richard Noback, M.D., director of University Health Service, all from Syracuse.

These were joined a few months later by the hospital administrator, Richard Wittrup, former assistant administrator of the University of Chicago Hospital, and the medical librarian, Alfred Brandon.

Recruiting of staff members continued into 1960, with the choice influenced by various new trends in the medical profession—increased emphasis on research, increased specialization and new knowledge based on psychology.

Key Positions

Administrative officers and department chairmen employed to date are:

a. William R. Willard, M.D., Vice-President for the Medical Center and Dean, College of Medicine
b. Marcia A. Dake, Ed.D., Dean, College of Nursing
c. Howard L. Bost, Ph.D., Assistant Vice-President for Program and Policy Planning
d. James A. Halsted, M.D., Assistant to the Vice-President and Director, Postgraduate Medical Education
e. Robert L. Johnson, Director, Community Services
f. Richardson K. Noback, M.D., Director, University Health Service
g. Alfred N. Brandon, Medical Librarian
h. Richard D. Wittrup, Hospital Administrator
i. William H. Knisely, Ph.D., Chairman, Department of Anatomy
j. Robert Straus, Ph.D., Chairman, Department of Behavioral Science
k. George W. Schwert, Ph.D., Chairman, Department of Biochemistry
l. Kurt Deuschle, M.D., Chairman, Department of Community Medicine
m. Edmund D. Pellegrino, M.D., Chairman, Department of Medicine
n. Wellington B. Stewart, M.D., Chairman, Department of Pathology
o. John H. Githens, M.D., Chairman, Department of Pediatrics
p. Loren D. Carlson, Ph.D., Chairman, Department of Physiology
q. Joseph B. Parker, Jr., M.D., Chairman, Department of Psychiatry
r. Harold D. Rosenbaum, M.D., Chairman, Department of Radiology

Inaugural Class

The 40 students accepted for the first class of the College of Medicine are:

Manuchehr Alavi, Tehran, Iran
Kranklen K. Belhasen, Paintsville
Dale W. Bennett, Lexington
J. Roy Biggs, Paducah
Joseph R. Bowling, Jr., New Haven
Troy L. Burchett, Stambaugh
Joe Clark Christian, Lexington
James A. Cunningham, Lexington
M. Allen Dawson, Jr., Versailles
Claude H. Farley, Jr., Pikeville
Martin Gebrow, Louisville
Richard E. Geist, Ashland
David L. Gullett, West Liberty
Thomas W. Hagan, Louisville
Mallory T. Harling, Dayton, Ohio
Lt. (j.g.) Arthur A. Hellebusch, Lyndon
John J. Hutton, Jr., Ashland
Danny H. Kaufman, New York, N. Y.
Maxwell C. Kimball, Rock Island, Ill.
Don W. Kreutzer, Southgate
Daniel C. MacDougall, III, Clarksville, Ind.
James M. McGowan, Paducah
Mary E. McMichael, Lexington
William R. Markesbery, Florence
William T. Maxson, Lexington
William Joseph Moore, Lexington
Michael S. Nall, Ashland
Donald R. Neel, Owensboro
Michael Lee Peveler, Louisville
Glynn E. Reynolds, Waynesburg
Helmuth Scherer, Georgetown
Patrick J. Serey, Ashland
Murph M. Slusher, Pineville
Wallace B. Sullivan, Stearns
Robert R. Threlkeld, Memphis, Tenn.

(Continued on Page 1222)

ORGANIZATION SECTION

1960 Rural Health Conference Set for October 27

The role of health in relation to economic development and health careers for Kentucky's youth will be the dual themes of the eighth annual Rural Health Conference at Morehead State College on Thursday, October 27. Announcement of the 1960 conference "Partners in Health," was made jointly by Mitchell B. Denham, M. D., Maysville, chairman of the Rural Health Council, and D. L. Graves, M. D., Frenchburg, program chairman.

An address by Governor Bert Combs will highlight the luncheon session of the one-day meeting which will be held in the school's cafeteria. All Kentucky residents are invited to attend. Last year's conference in Bowling Green was attended by 154 from throughout the state.

The conference's sponsoring group, the Rural Health Council is comprised of about 20 civic organizations, including the KSMA, interested in improving the health care of our rural citizens.

Following is the conference program:

MORNING SESSION

John Koon, executive secretary, Kentucky Farm Bureau, presiding

9:00 Registration

9:25 Invocation, Henry Haggan, Head of Agricultural Dept., Morehead State College

Announcements, D. L. Graves, M.D., Frenchburg, program chairman

Greetings, J. C. Zimmerman, director industrial development, Kentucky Chamber of Commerce

10:00 Panel—"Health in Relation to Economic Development—The Problem"

P. F. Ayer, Berea, executive secretary, Council of Southern Mountain Workers, moderator

Alec Spencer, M. D., West Liberty

B. F. Reed, Drift, chairman, Eastern Kentucky Regional Planning Commission

Dr. Jim Brown, University of Kentucky Sociology Dept., Lexington

10:45 Milk Break—Served by Dairy Princess

11:00 Panel—"Health in Relation to Economic Development—Present and Available Resources"

Edwin H. West, M.D., director of local health service, State Health Department, Frankfort

Otto Ingram, Judge, Menifee County

Scott True, Maysville, Farm Director WFTM

Dave Aronberg, Mayor, Ashland

11:40 What Can—What Have—And What Are We Going To Do?"

Audience Participation

LUNCHEON SESSION

Mitchell B. Denham, M.D., Maysville, chairman, Rural Health Council, presiding

Address—Governor Bert Combs

Dinner Music—Mrs. Adron Doran

AFTERNOON SESSION

Miss Alda Henning, Lexington, UK Agricultural Extension Service, presiding

1:45 Panel—"Careers in Health"

Dr. Frances Hutchens, president Berea College, moderator

E. B. Gernert, D. M. D., State Health Dept., Frankfort

C. C. Howard, M.D., Glasgow, chairman Rural Kentucky Medical Scholarship Fund

Fred Martin, director, Industrial and Distributive Education, Frankfort

Bob Johnson, director, Community Services, University of Kentucky Medical Center, Lexington

3:15 Farewell Address, Dr. Adron Doran, President, Morehead State College

Diabetes Week Nov. 13-19

KSMA members are reminded of the annual Diabetes Detection and Education Drive November 13-19. Franklin B. Moosnick, M.D., Lexington, chairman of the KSMA Diabetes Committee, urges every physician to do his part by encouraging public participation in the effort and by checking urine samples free for the week of the campaign.

Better Kentucky Roads Sought Through Bond Issue

Cost of Kentucky's participation in the nation-wide Interstate highway system is small compared to the benefits to be gained for rural road construction and maintenance, according to the Kentucky Better Roads Council.

The Council, a non-partisan group of citizens, reactivated to help secure public approval of the $100-million highways and parks bond issue which will go before the voters November 8. If approved by the voters, 10 million dollars will be set aside for further development of state park facilities and attractions. The remaining $90 million will be used on highway projects to which the federal government contributes funds.

Only $4.2 millions a year of the proposed bond money will be required to match Federal interstate expenditures, while $15.2 millions will go into rural



The nation's capital, Washington, D. C., will also be the capital of American medicine November 28—December 1 during the 14th Clinical Meeting of the American Medical Association. Headquarters will be in the Sheraton-Park Hotel and scientific activities will be held in the National Guard Armory.

secondary, primary and urban improvements, according to the council. This represents more than 19,000 miles of Kentucky roads. The interstate system of 641 miles is an interlocking part of the national system of 41,000 miles.

Editor's Note: The KSMA House of Delegates, at its September 21 session, unanimously passed a resolution endorsing the Parks and Highway Improvement Bond proposal. A full report will be carried in the November issue of the Journal.

Members Seek School Board Posts In November Election

Four KSMA members have announced their candidacies for membership on their local boards of education in the November election.

Melvin Dean, M. D., Lexington, a member of the Fayette County Board of Education since June, 1954, will be up for re-election. Clyde T. Moore, M. D., Fern Creek, has filed for the District Three seat on the Jefferson County Board of Education.

Running for a seat on the Louisville Board of Education is William W. Nicholson, M.D. E. M. Holmes, M. D., is running for one of the two vacancies in the Anchorage School Board.

These were the only candidacies that had come to the attention of the Journal staff at press time; however, there may be others.

Commenting on their intentions to serve their communities on the boards of education, Richard G. Elliott, M.D., Lexington, KSMA president, called their willingness to accept civic responsibility admirable.

AMA Clinical Meeting To Open In Washington Nov. 28

A well-rounded and stimulating program designed to interest both family physicians and specialists is announced by the American Medical Association for its 14th Clinical Meeting in Washington, D. C., November 28-December 1. Outstanding physicians from throughout the nation will conduct the scientific sessions.

The symposia, presentations and discussions will stress the theme, "New Developments In Old Diseases and Old Developments in New Diseases."

The patient's side will be heard on one symposium when Clarence B. Randall, special assistant to President Eisenhower, talks on coronary disease from the patient's viewpoint.

Maj. Gen. Howard McC. Snyder, M.C., U.S.A., personal physician to the President, will be the guest of honor at the House of Delegates dinner on November 28. President Eisenhower has been invited and is expected to attend if his official schedule permits.

Headquarters will be in the Sheraton-Park Hotel and most scientific sessions will be held in the District of Columbia National Guard Armory. Approximately 125 scientific exhibits and more than 100 industrial exhibits have been scheduled.

John A. Wilson, M.D., has started the general practice of medicine at Guthrie. Doctor Wilson, a graduate of the University of Louisville School of Medicine in 1956, served in the U. S. Navy from 1956-59 and took his internship at the U. S. Naval Hospital, Portsmouth, Va.

M.D.'s Participate In Governor's Conference On Aging

KSMA was well represented among the approximately 400 persons who attended the Governor's Conference on Aging held September 1-2 at the University of Louisville. Purpose of the two-day meeting was to make recommendations for Kentucky's contribution to the White House Conference on Aging set for January 9-12 in Washington.

Kentucky has 32 delegates to the 1961 Conference, five of whom are KSMA representatives. They are John C. Quertermous, M. D., Murray; George Archer, M. D., Prestonsburg; Ben H. Hollis, M. D., J. W. Hancock, M. D., and Robertson O. Joplin, M. D., Louisville.

The Governor's Conference was devoted primarily to workshops in seven categories: Health and Medical Care, Income Maintenance and Employment, Housing and Living Arrangements, Education and Recreation, Community Organization, Social Studies and Religion.

Appearing on two of the panels were two AMA representatives. Frederick C. Schwartz, M. D., Lansing, Mich., chairman of the AMA Committee on Aging, took part in the workshop on Health and Medical Care, and John Guy Miller, Chicago, director of Aging and Chronic Illness for AMA, participated in the workshop on Housing and Living Arrangements.

Represented at the conference were medical and dental groups, senior citizen clubs, nursing home operators, social workers, federal and state groups and the Chamber of Commerce, among others.

Dr. Horine Giving Large Part Of His Book Collection

Emmet Field Horine, M.D., of Brooks, official KSMA historian, is giving several thousand of his books and papers to various Kentucky universities and members of his family. His collection, which numbers over 15,000 volumes, has been called "one of the most distinguished private collections in the United States."

An article entitled "Destiny Fulfilled," telling of his intention to give away most of his collection, appeared in the Louisville *Courier-Journal* Magazine Section on Sunday, September 11.

The University of Kentucky is announcing and exhibiting his gift of a 30-to-40 item collection on Michael Servetus who first described pulmonary circulation of the blood. A second and large collection, which goes to the U. of K. Medical Center, is made up of 1,500 items on William Harvey, discoverer of the circulation of the blood.

A still larger collection, consisting of some 1,600 items on anesthesiology, will be given to the University of Louisville after a bibliography is prepared by Eugene Conner, M.D., professor of anesthesia and acting chairman of the Jefferson County Medical Society's library committee. To the Medical Department of Transylvania University (1799-1857), now housed in Transylvania College, Lexington, he is leaving many of his early medical books, including those on the heart, printed before 1800.

Doctor Horine is the author of two books being published this year. *Biographical Sketch and Guide to the Writings of Charles Caldwell, M.D. (1772-1853)* came out in July. The other, *Daniel Drake, M.D., (1785-1852) Pioneer Physician of the Midwest,* will appear late this fall from the University of Pennsylvania Press. Besides his other medical writing, as KSMA historian he has written more than 25 biographical sketches of early presidents.

Many of his books on cardiology will go to his son-in-law, Carleton B. Chapman, M.D., professor of medicine and director of the cardiopulmonary laboratory of the Southwestern University of Dallas, Texas. Others will be given to other members of his family.

Farm Bureau Asks Membership For Policy On Care of Aged

The Farm Bureau, in a special article in the September issue of the Kentucky Farm Bureau News, is asking its members to help establish a position on the controversial issue of providing medical care for the aged.

The organization's present policy opposes a compulsory health insurance system proposed in a number of bills that have been introduced into Congress. It takes the stand that medical care for older persons can be provided best and at least cost through the voluntary system, such as insurance policies and Blue Cross-Blue Shield.

However, the article points out, this position can be changed by a majority vote of the state delegates at any national Farm Bureau convention.

Pros and cons of the issue are discussed at length, and a questionnaire is presented for members to check. Questions asked are: (1) Do you feel that medical care for the over-65 group is such a pressing problem right now that a federal program needs to be passed immediately? (2) Do you believe that the voluntary health insurance plan (insurance companies, Blue Cross, etc.) are doing a good job of meeting this problem? (3) Who has the responsibility for medical care of older people? (4) How should a medical care plan be run and financed?

Third Norton Seminar Set Dec. 15

The third annual Norton Memorial Infirmary Postgraduate Medical Seminar is scheduled for Thursday, December 15, at the infirmary in Louisville.

The program will open at 9 a.m. with coffee, followed at 10 a.m. by a scientific session offering a presentation on "Office Cytology" and a symposium on "Acute Abdominal Crises." The afternoon will be devoted to miscellaneous medical presentations including a talk on "Medicine and the Law" by Harry W. Ginty, secretary and chief of the legal department for Medical Protective Company, Fort Wayne.



Advisory Council on Medical Assistance Meets

The first meeting of the 11-member State Advisory Council on Medical Assistance was held in Frankfort on September 16 at the call of the Governor, who termed the group "one of the most important Councils in our State Governmen." G. L. Simpson, M.D., Greenville, seated center, was elected chairman; E. M. Josey, seated left, of the Kentucky Pharmaceutical Association, Frankfort, was named vice-chairman, and Edward E. Ellis, seated right, of the Kentucky Welfare Association, Frankfort, was elected secretary. Other members are, front row standing, from left: Tarleton Collier, Louisville, citizen at large; Nelle B. Weller, R. N., Louisville, Kentucky State Association of Registered Nurses; Virginia Craft, Whitesburg, citizen at large, and Russell E. Teague, M.D., Frankfort, Commissioner of Health; back row: C. D. Carter, D.M.D., Bowling Green, Kentucky Dental Association; Jo M. Ferguson, Frankfort, Commissioner of Economic Security; Howard L. Bost, Ph.D., Lexington, Kentucky Hospital Association, and Seth Boaz, Mayfield, citizen at large. The second meeting of the Council was scheduled for October 10.

U. of L. Faculty Members Receive Grants for Study

Two members of the faculty of the University of Louisville School of Medicine recently received grants for study in their specialties.

Wallace L. Past, M. D., assistant professor of pathology, has received a three-year $29,000 grant from the National Institutes of Health, Bethesda, Md. He will study the metabolism of iron in body tissues—its behavior in various types of cells. One phase of his study will seek to find if there is any relationship between iron and hardening of the arteries.

A $29,137 grant from the United States Public Health Service has been awarded to Kenneth P. McConnell, Ph.D., associate professor of biochemistry. Dr. McConnell, who is also a director of the Veterans Hospital radioisotope laboratory, will work with radioactive selenium, a trace element that may be related to certain muscle diseases.

Film On U. K. Medical Center Set For SMA Viewing

A film on the development of the University of Kentucky Medical Center will be shown on television in the St. Louis area during the meeting of the Southern Medical Association there on October 20, 21, and 22.

The half-hour, colored television documentary co-sponsored by the Southern Medical Association and Merck, Sharp and Dohme, will focus upon the registration and welcome of the first class of students and will then flash back to the events leading to the ultimate creation of the center, including the time when Dr. Frank McVey, the third president of the U. of K., started investigating the need for a medical school.

John Cameron Swayze is featured as interviewer and narrator of the film which is being produced by Advantage Enterprises, Inc., New York City.



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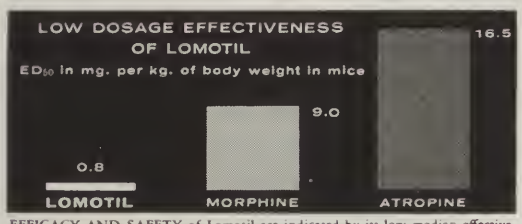
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Research in the Service of Medicine

PG Course In Ob.-Gyn. Planned Nov. 9-10 In Louisville

Postgraduate course in Obstetrics and Gynecology is scheduled for November 9 and 10 at the Kentucky Hotel in Louisville.

Sponsored by the KSMA postgraduate department, the University of Louisville, University of Kentucky, the Kentucky Obstetrical and Gynecologic Society, and the KAGP, the course has been approved for Category 1 credit by the AAGP. All the participants, with one exception, are members of the University of Louisville School faculty.

No fees will be charged for the meeting. Following is the two-day program:

Wednesday, November 9

8:30 Registration-Room A, 2nd Floor
9:45 Welcome, Douglas M. Haynes, M.D.
10:00 Opening of General Session
"Basic Gynecological Examination," William E. Pugh, M.D.
10:30 "Early Detection of Cancer," Laman A. Gray, M.D.
11:00 "Psychosomatic Gynecology," Robert C. Long,
11:30 Lunch
1:00 "Disturbances in Menstruation," Harold W. Baker, M.D.
1:30 "Abnormal Bleeding"—(Panel Discussion)
Moderator—Jennings Marshall, M.D.
Robert C. Long, M.D.
Harold W. Baker, M.D.
Rudy F. Vogt, M.D.
3:00 Question Period, followed by adjournment
6:00 Social Hour—Room A- Second Floor
7:00 Dinner—Room A—Second Floor

Thursday, November 10

10:00 "Antepartum Care," Silas H. Starr, M.D.
10:30 "Toxemia of Pregnancy," Panel Discussion
Moderator—Silas H. Starr, M.D.
Douglas M. Haynes, M.D.
John D. Gordinier, M.D.
William H. Powers, M.D.
12:00 Question Period Followed by Lunch
1:30 "Rh and ABO Incompatibility," Glenn W. Bryant, M.D.
2:00 "Bleeding in Late Pregnancy," Douglas M. Haynes, M.D.
2:30 Question Period, followed by adjournment

50 At First-Third District Meet

Fifty physicians and wives attended the joint meeting of the First and Third Councilor Districts at Kentucky Dam Village on August 25, it is reported by Hugh L. Houston, M. D., Murray, and Ralph D. Lynn, M. D., Elkton, councilors of the respective districts.

The program featured an address, "The Last Chance," by Irvin Abell, Jr., M. D., Louisville, KSMA president, and a scientific presentation, "Some Current Concepts On the Actions of Digitalis," by Edmund D. Pellegrino, M. D., Lexington, professor and chairman of the Department of Medicine, University of Kentucky Medical Center.

AMA Program On Medical Aspects Of Sports Set For Nov. 27

The Second National Conference on the Medical Aspects of Sports, sponsored by the AMA Committee on the Medical Aspects of Sports, is planned for November 27 at the Statler Hotel in Washington, D.C. The program will immediately precede the annual AMA Clinical Meeting, November 28 to December 1.

The conference will present papers, panels and discussions covering a wide range of subjects, including the prevention and treatment of injuries, training and conditioning, and the psychology of sports.

Further information may be obtained by writing to: Fred V. Hein, Ph.D., Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn, Chicago 10, Ill.

Bailey Fund Grants First Loan

First student loan awarded under the W. Clark Bailey Memorial Fund established by the Harlan County Medical Society, was granted to Norman Edwards, a native of Harlan.

A member of the freshman class at the University of Louisville School of Medicine, Edwards received a loan of $1,000. Sanford Weiler, M.D., is chairman of the fund. Contributions are tax deductible and members wishing to contribute to this fund established in the late Doctor Bailey's memory may do so by sending their contributions to W. Clark Bailey, Jr., Harlan, Fund treasurer.

SMA Auxiliary to Meet In St. Louis

The 36th annual meeting of the Woman's Auxiliary to the Southern Medical Association is scheduled for October 31-November 3 at the Statler-Hilton, in St. Louis, it is announced by Mrs. Robert Monroe, Louisville, Kentucky Councilor for the Auxiliary. In addition to the business sessions, the program will include a tea and fashion show and a number of sightseeing trips. The Doctors Day Award Luncheon on November 2 will highlight the activities. During the meeting Mrs. Kalford W. Howard, Portsmouth, Va., will be installed as president to succeed Mrs. John M. Chenault, Decatur, Ala. Among the Auxiliary's committee chairmen is Mrs. Carlisle Morse, Louisville, who heads the Revisions Committee.

146 M.D.'s Attend Clinical Meet

One hundred forty-six physicians registered for the Symposium on Clinical Medicine conducted in Lexington on August 21 by the Kentucky Academy of General Practice and the University of Kentucky Medical Center. Attendance, with 58 wives and 15 other guests, totaled 219.

Arnold C. Williams, M.D., Lexington, was chairman of the program.

Diabetes Detection Week Nov. 13-19

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PG Medical Opportunities Listed For Next Three Months

Postgraduate medical opportunities in Kentucky and adjoining states for the next three-month period are announced by the KSMA Postgraduate Medical Education Office.

Special attention is called to the two-day course on Chronic Disease, set for October 19 and 20 at Bowling Green, and also a two-day course on Obstetrics and Gynecology, set for November 9 and 10 at Louisville. These are the first of a series planned to cover various locations over the state and designed to serve the general practitioners of Kentucky.

Detailed information on the listings may be obtained from the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2. The telephone number is JUniper 7-7135.

The complete listing follows:

October

17-29 Postgraduate course, "Laryngology and Bronchoesophagology," sponsored by the University of Illinois College of Medicine, Department of Otolaryngology, under direction of Paul H. Holinger, M.D.; limited to 15 physicians. Register at the university, 1853 West Polk Street, Chicago 12, Ill.

18 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

19-20 Postgraduate course in Internal Medicine; "John Walker Moore Visiting Professorship" sponsored by Louisville Society of Internists; visiting professor, Eugene Stead, M. D., chairman of the Department of Medicine, Duke University; General Hospital, Louisville.

19-20 Postgraduate course, "Chronic Diseases," with scientific lectures, panel discussion and question period; sponsored by Kentucky State Department of Health, KSMA Postgraduate Medical Fund, U. of L. School of Medicine and U. of K. Medical Center; Ole Fort Restaurant, Bowling Green, Ky.; 2 p.m. Category I credit applied for. No fees.

19-20 Louisville Society of Internists, postgraduate meeting; Louisville.

20-22 Southern Medical Association, meeting; Hilton Hotel, El Paso, Texas.

27 Fifth Annual Fall Clinical Conference of the Lexington Clinic, Lexington.

28 Kentucky Chapter, AAGP; meeting at Maysville. Registration at 12 noon; meeting starts at 1 p.m.

29 Kentucky Chapter of the American College of Physicians, regional meeting; Lexington.

November

3-4 Postgraduate course "Allergy," University of Tennessee College of Medicine, Memphis.

9-10 "Postgraduate Course in Ob-Gyn," sponsored by the KSMA Postgraduate Medical Office, Kentucky State Department of Health, University of Louisville, University of Kentucky and the Kentucky Academy of General Practice; Kentucky Hotel, Louisville, 10 a.m.; no fees; limited to 50 persons.

15 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, State Tuberculosis Hospital, District 2, Louisville.

17 Postgraduate course, "Neurology and Psychiatry in General Practice," University of Nebraska, College of Medicine, Omaha.

17-19 Postgraduate course, "Orthopedic Surgery;" University of Texas Southwestern Medical School, Dallas.

December

9-10 Postgraduate course, "Neurology;" University of Texas Southwestern Medical School, Dallas.

15 John N. Norton Memorial Infirmary Medical Seminar; postgraduate course; John N. Norton Memorial Infirmary, Louisville.

20 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

December through January—Tentative intermittent course (12 weeks, ½-half day each week) on EKG Interpretation; Louisville General Hospital.

January

6 Postgraduate course, "Ophthalmology;" University of Texas Southwestern Medical School, Dallas.

19-20 Postgraduate course. "Obstetrics & Gynecology;" University of Nebraska College of Medicine.

PG Ophthalmic Course Planned

A postgraudate course in ophthalmic surgery, sponsored by the Department of Ophthalmology, Emory University School of Medicine, will be held in the auditorium of the Grady Memorial Hospital, Atlanta, Ga., on December 1 and 2.

Guest lecturers will include: Frank D. Costenbader, M. D., Washington Hospital Center, Washington, D. C.; John M. McLean, Cornell University School of Medicine, New York, N. Y.; and Harold G. Scheie, University of Pennsylvania School of Medicine, Philadelphia. Diagnostic principles and techniques, preoperative and postoperative management, and surgical principles and techniques in extraocular muscle surgery, cataract surgery and glaucoma surgery will be discussed by this distinguished faculty.

New KSMA Members

James G. Sills, M. D., Hardinsburg
Paul R. Smith, M.D., Harlan.

NEWS ITEMS

Richard M. Beaven, M.D., has opened an office in Bowling Green for the general practice of medicine. He previously practiced three years at Russellville. Doctor Beaven, a native of St. Marys, received his medical degree from St. Louis University in 1956 and interned at Milwaukee County Hospital. He served in the U.S. Navy from 1946 to 1947.

Milton O. Beebe, M.D., has moved from Hazel Green to Versailles, Ind., where he is associated with John Parker, M. D. Doctor Beebe operated the clinic at Hazel Green the past two years, in addition to his other practice.

Roger A. Haas, M.D., has started practice in Newport in association with Robert G. Draime, M.D. A native of Ft. Thomas, Doctor Haas received his medical degree from the University of Cincinnati in 1959 and interned at Christ Hospital, Cincinnati.

William J. Mersch, M.D., has started the practice of general surgery in his native Covington, in association with Edward B. Mersch, M.D., after completing four years of residency training at Henry Ford Hospital, Detroit. A 1953 graduate of the University of Cincinnati, Doctor Mersch interned at Cincinnati General Hospital. His residency training was interrupted for two years, April 1955 to April 1957, by service in the U.S. Army, where he attained the rank of captain.

David Y. Keith, M. D., has given up his practice at Paducah and moved to Perrine, Fla. The first of July he was accepted by the University of Miami and Jackson Memorial Hospital to participate in the National Institute of Mental Health's program to train psychiatric residents from the ranks of general practitioners who have been in practice over five years. A native of Jefferson county, Doctor Keith received his M.D. degree from the University of Louisville School of Medicine in 1944.

Dennis B. Penn, M.D., has started practice in Lexington in association with Carl L. Wheeler, Jr. M. D. His specialty is pediatrics. Born in Georgetown, Doctor Penn received his M.D. degree from University of Louisville School of Medicine in 1955. He took internship and residency training at St. Joseph Infirmary, Louisville, and spent two and a half years in the U. S. Navy.

L. C. Wray, M. D. Huntington, W. Va., was recently named new health director of Daviess, McLean, and Hancock counties. A native of Kentucky and a graduate of the University of Louisville School of Medicine, Doctor Wray worked in the public health field at Leitchfield in the 1930's. More recently he has been in private practice in Huntington. His predecessor, **B. F. Brown M. D.,** will spend a year studying at the University of North Carolina before taking a new position with the State Department of Health in Frankfort.

Frank T. Smith, M.D., has opened an office in Middlesboro for the general practice of medicine. He will also practice in Clairfield, Tenn. A native of Gallatin, Tenn., Doctor Smith received his medical degree from the University of Tennessee in 1958, interned at Nashville General Hospital, and practiced eight months at Jamestown, Tenn. He served in the U. S. Navy from 1950-53.

Paul Ray Smith, M.D., a 1956 graduate of the University of Louisville School of Medicine, has started the general practice of medicine in London. He took his internship training at Good Samaritan Hospital, Lexington, in 1956-57. After a year of practice in Lynch, he left to serve two years as a captain in the USAF.

John Joseph Salter, M.D., a native of San Antonio, Texas, has located in Harlan to practice in association with Miners Memorial Hospital. His specialty is pathology. A 1939 graduate of the St. Louis University School of Medicine, Doctor Salter interned at Santa Rosa Hospital, San Antonio, and spent four years in residency training in pathology at hospitals in San Antonio and Chicago. He served five years in the U. S. Army Medical Corps, retiring with the rank of major. He was in private practice in San Antonio three and a half years and in the Chicago area from 1955-1960.

Ralph M. Scott, M.D., recently became director of the Louisville Medical Center's new cancer-research and treatment center. Although the $250,000 Center is not yet a reality, Doctor Scott will help in planning and setting it up. A native of Leemont, Va., he is a graduate of the Medical College of Richmond in 1950. A board certified radiologist, he took graduate training at Robert Packer Hospital, Sayre, Pa., the University of Chicago, and at Christie Hospital and Holt Radium Institute in Manchester, England. In 1957, he took charge of radiation therapy and nuclear medicine at Robert Packer Hospital and became assistant professor of radiology at the University of Chicago Medical School last August.

Morton G. Waterman, M.D., has opened an office in the Francis Building, Louisville, for the practice of general surgery. A native of Louisville, Doctor Waterman was graduated from Harvard Medical School in 1955 and took his internship and residency training at Barnes Hospital, St. Louis. He served in the U.S. Army from 1950 to 1951.

Wilk O. West, M.D., has joined the staff of the Lexington Clinic, Lexington, limiting his practice to internal medicine and hematology. A native of Princeton, W. Va., Doctor West was graduated from the Medical College of Virginia in 1955. He interned and took residency training at Memorial Hospital, Charleston, W. Va., after which he was a resident at University Hospital, Columbus, Ohio, from 1958 to 1960.

NEWS ITEMS

Ezra V. Seay, M.D., was recently honored on his 89th birthday as the oldest member of the Salvisa Christian Church. Despite his age, Doctor Seay is still in active practice. He commutes from Lawrenceburg and has office hours from 8 a.m. to 5 p.m. seven days a week just as he has since 1905. Following ceremonies eulogizing Doctor Seay, he was the guest of honor at an old-fashioned dinner on the church grounds attended by many of his patients, friends and fellow physicians.

James F. Siles, M.D., has opened an office in Latonia for the general practice of medicine. A 1958 graduate of the University of Louisville School of Medicine, Doctor Siles interned at St. Elizabeth Hospital, Covington. He served one and a half years, 1945-47, in the U. S. Army and in the USAR 12 years. Doctor Siles is a native of Covington.

D. N. Tweeddale, M.D., has joined the staff of the Trover Clinic in Madisonville, where he will limit his practice to pathology. A native of San Francisco, Calif., he was graduated from Creighton University Medical School in 1951. Doctor Tweeddale, who previously practiced in Cleveland and Painesville, Ohio, interned at St. Elizabeth Hospital, Lincoln, Neb., and took residency training at Lincoln General Hospital, Lincoln, and at the Mayo Clinic, Rochester, Minn.

A. C. Overall, M.D., and **Mrs. Overall,** Lawrenceburg, celebrated their 50th wedding anniversary with a reception at the home of Mr. and Mrs. Thomas B. Ripy on Sunday, August 14. Doctor Overall began the practice of medicine in Lawrenceburg in 1904.

Paul Maurice Taylor, M.D., has begun the general practice of medicine in Providence. A native of Earlington, Doctor Taylor received his medical degree from the University of Louisville School of Medicine in 1959 and interned at City Hospital, St. Louis.

Dr. Cecil Speaks in Louisville

Russell Cecil, M. D., noted New York rheumatologist, spoke at a panel discussion sponsored by the Kentucky Chapter, Arthritis and Rheumatism Foundation in Louisville early in September. David H. Neustadt, M. D., Louisville, chairman of the chapter's medical and scientific committee, presided.

U.K. Medical College Gets Grant

The University of Kentucky College of Medicine has received a grant of $18,766 from the American Cancer Society for an 18-month study of "the production of tumors in mice with cell-free extracts from normal heterologous tissues."

The research will be under the supervision of Kingsley M. Stevens, M.D., of the medical college staff.

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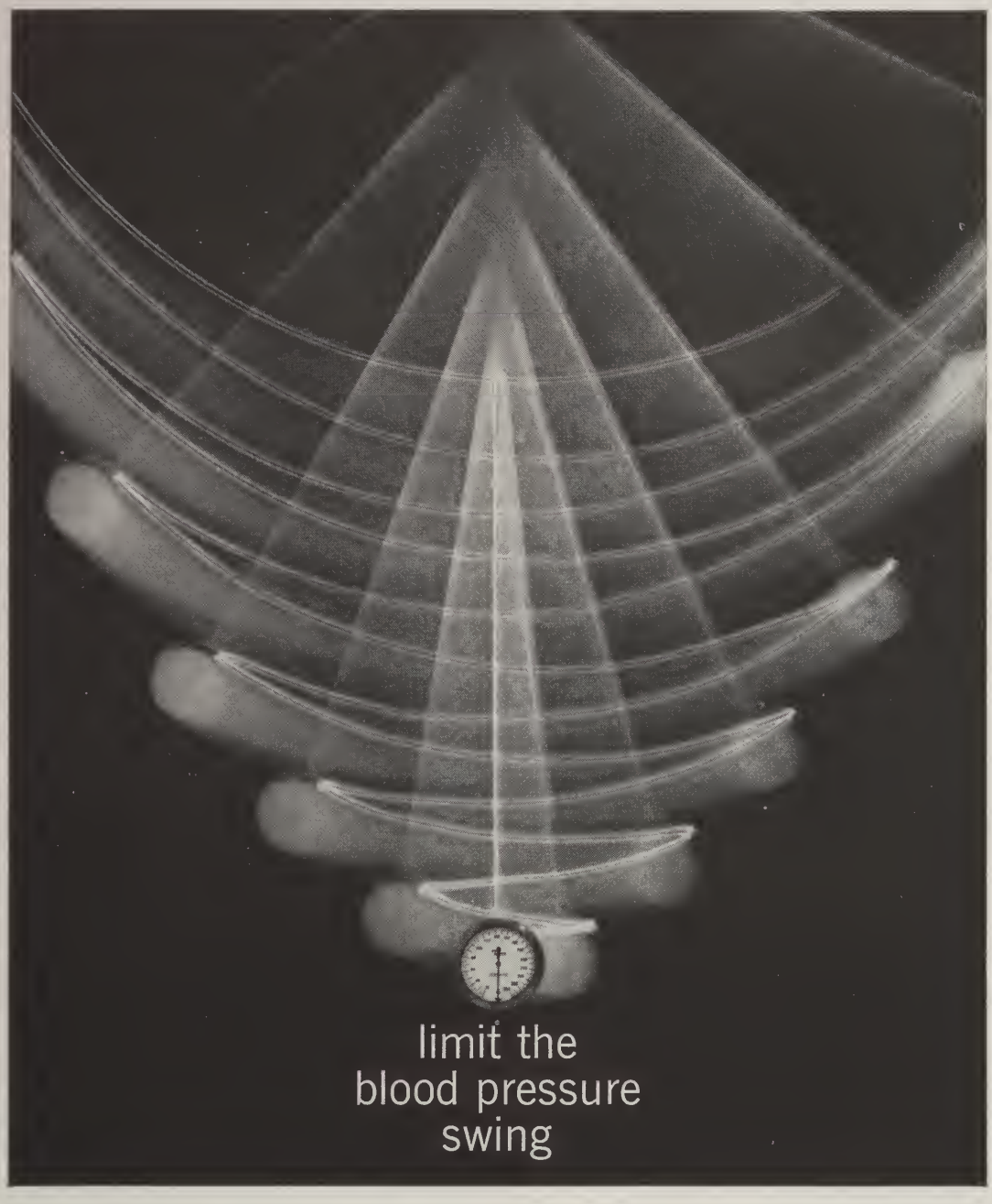
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IN THE BOOKS



LIVING BEYOND YOUR HEART ATTACK: by Eugene B. Mozes, M. D.; published by Prentice-Hall, Inc., Englewood Cliffs, N.J.; 212 pages; price, $3.50.

The author presents to the public an accurate, concise, readable and authoritative review of coronary heart disease. He uses as references very distinguished authors and the latest in medical literature. In other words, this is a comprehensive review of the literature on coronary heart disease presented in a way for the lay person who has suffered a coronary attack.

I was very much impressed with the simplicity of the explanations of so complex a subject and with the ability of Dr. Mozes to present this feared disease state in a manner which should allay the fears of the public. He explains that coronary disease does not necessarily mean cardiac crippling and his reasoning is quite convincing. I was particularly impressed with some of the charts on energy expenditure by the body in various types of activities and I believe this information should be disseminated to all cardiac patients.

Dr. Mozes goes into the treatment and prevention, including the rational of anti-coagulants and dietary fat or cholesterol restrictions. He does not choose sides, yet presents the subject in a fair manner.

I heartily recommend this book for all patients with coronary disease and feel that physicians who handle these patients could probably benefit from this book.

F. Albert Olash, M. D., F.A.C.P.

THE OLDER PATIENT: by 21 authors—edited by Wingate M. Johnson, M. D.; published by Paul B. Hoeber, Inc., New York, 1960: 589 pages: price $14.50.

This book of 26 chapters is necessarily brief on each subject but with emphasis on its application to the older patient. For a complete review of the clinical entity, another, a fuller book, should be consulted. But this book is rewarding in its accent on the aged patient.

The method of presentation varies with the different authors. Some take up by the systems and give the variations and special handling for the older patient. Some present syndromes and briefly give the more likely things that happen in the aged. Some take the clinical entity and present it much as other medical texts with a great deal of application to the older patient. The latter style was used in Diseases of the Heart and Blood Vessels, Pulmonary Disease, and Gastrointestinal Tract and Digestive Organs. These are quite full and interesting.

There are some case presentations in some of the chapters. They are brief but quite helpful to the running text.

The book contains several figures, plates of pathological specimens and x-rays that make the reading more interesting and understandable.

The experience of each author is clearly reflected in his presentation and can be accepted for its authority.

This book is in a large, easy-to-read type with bold headings and a complete index. It would be a worthwhile addition to any physician's library, particularly the general practitioner.

Carlisle Morse, M. D.

CLINICAL OBSTETRICS AND GYNECOLOGY: Obstetrical Emergencies edited by Martin L. Stone, M.D.; Pediatric Gynecology edited by John W. Huffman, M. D.; published by Paul B. Hoeber, Inc., New York; 264 pages; published quarterly; subscription, $18 a year.

The first half of this volume deals with Obstetrical Emergencies. Anesthesia for Obstetrical Emergencies is discussed very completely, covering all agents in use today. A discourse on anesthesia for the patient who has recently eaten is especially timely and is one of the few times I have seen this problem covered in print.

A section on Failed Forceps paints a rather dismal picture for this procedure. Granted all is not well, a good outcome is possible if the complication is recognized in time.

Transverse presentation is discussed and cesarean section advised for all patients in labor. Internal podalic version has no place here, according to the author.

A very practical management of the Eclamptic patient is presented. There is good coverage of such topics as Rupture of the Uterus, Severe Abruptio Placentae, Acute Abdominal Emergencies and Postpartum Hemorrhages.

It was noticed that Cardiac Arrest occurred 35-40 x less frequent in the obstetrical patient. A good section on prophylaxis and treatment is given.

In summary this section gives a concise practical discussion of Obstetrical Emergencies and is a stimulating review for any prospective reader.

The second part of this book deals with Pediatric Gynecology. There is needless repetition in the discussion of vulvovaginitis as well as labial adhesions.

The section on Development of the Female Reproductive System During Adolescence gives a standard by which development may be measured. It was interesting to note that menarche is occurring earlier by some four months per decade.

There is discussion of vulvovaginitis, tumors of

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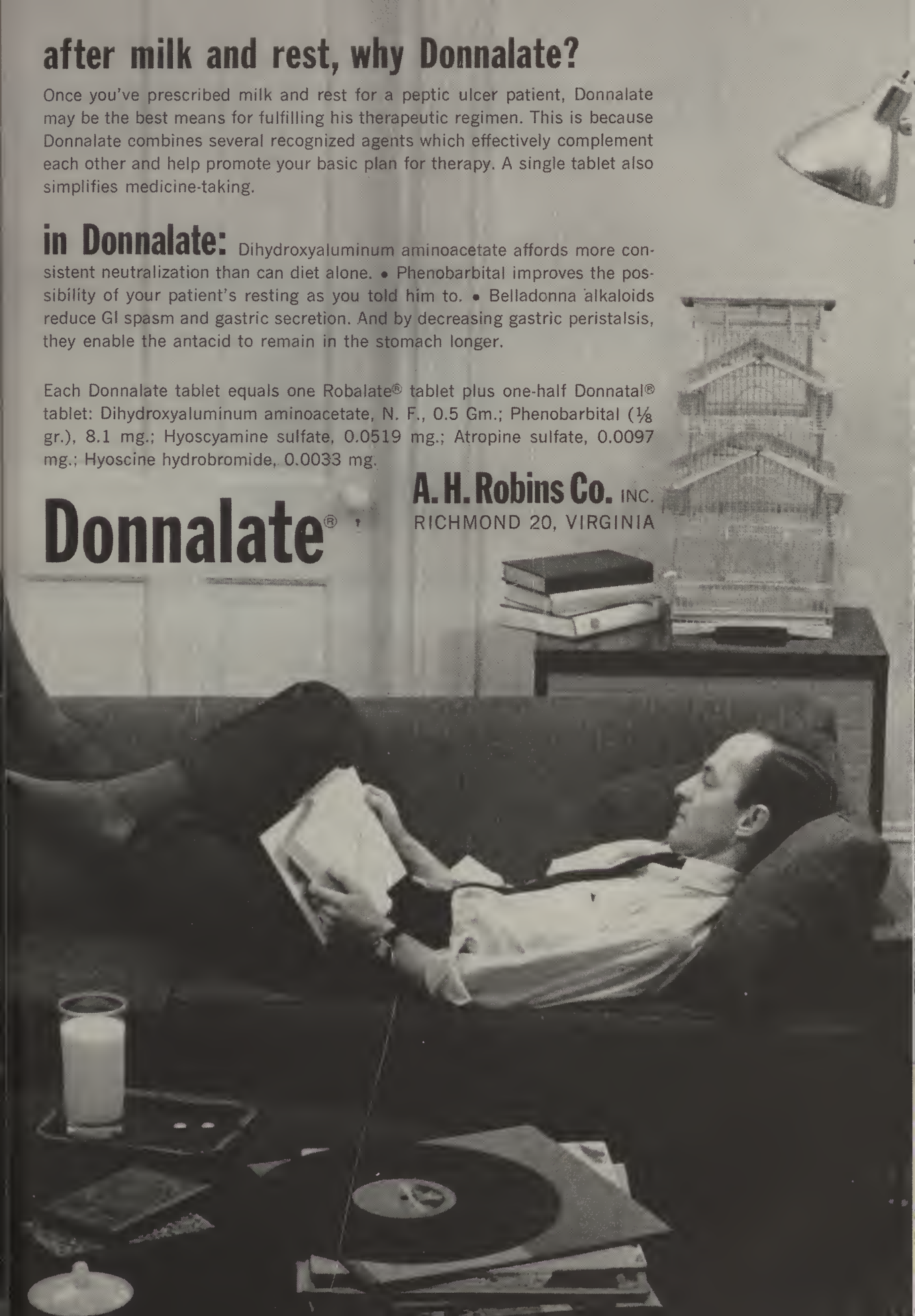
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IN THE BOOKS

Continued from Page 1218)

the vagina and uterus, tumors of the ovary, sexual precocity, Congenital Rudimentary Gonad Syndrome, Congenital Anomalies, the Intersexed Female, Dysmenorrhea and Dysfunctional Uterine Bleeding of Adolescence. There is good coverage on these topics.

The section on Pediatric Gynecology is well worth reading by anyone interested in Gynecology or Pediatrics and certainly would be helpful in dealing with the pelvic problems of the female child.

Glenn W. Bryant, M. D.

MEDICAL RESEARCH AND THE DEATH PENALTY: by Jack Kevorkian, M. D.; published by Vantage Press, Inc.; 75 pages; price, $2.50.

In his brief essay, Dr. Kevorkian proposes that in those states where the death penalty is imposed that the criminal be given the alternative of death by surgical anesthesia and agree that his body be used for medical research after the induction of anesthesia from which he would not be allowed to recover.

Although the author presents this in a convincing manner, his style in a dialogue between a protagonist and an antagonist is somewhat tedious and repetitive. Considering the amount of controversy about the death penalty itself, plus the mixed feelings in many quarters in even using laboratory animals for medical research, I suspect that Dr. Kevorkian will have a few difficulties in his crusade.

Frank M. Gaines, M.D.

U. OF K. MEDICAL SCHOOL

(Continued from Page 1204)

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Medical Science	$1,500,000
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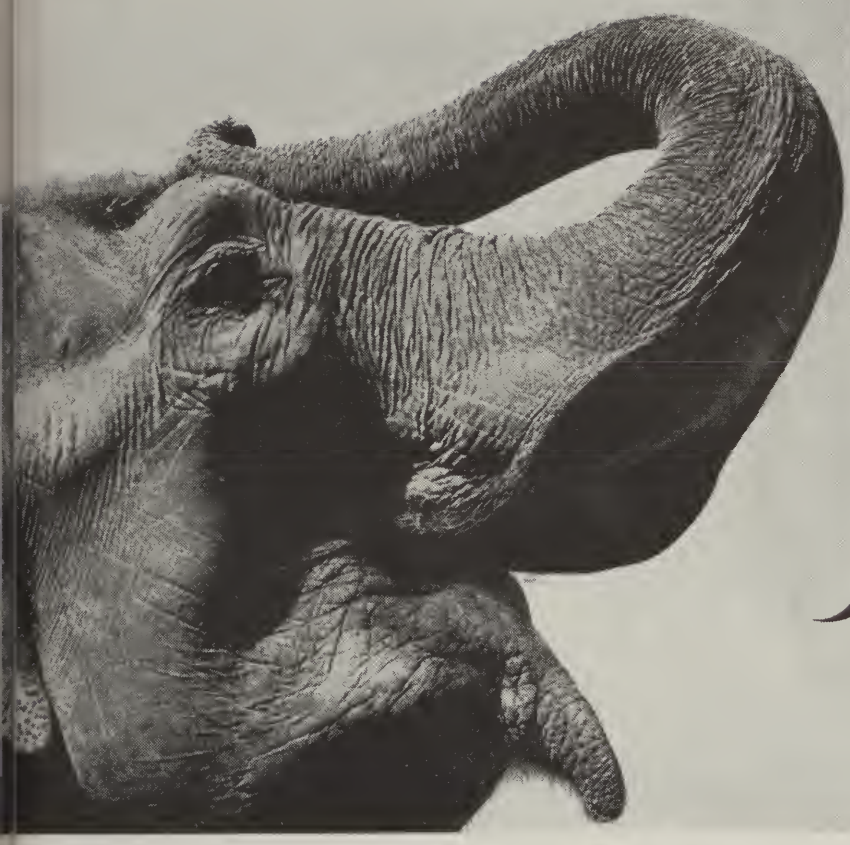
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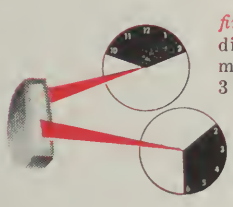
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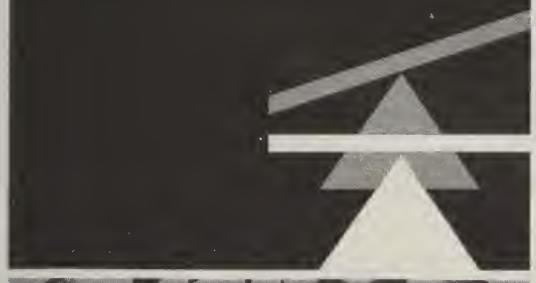
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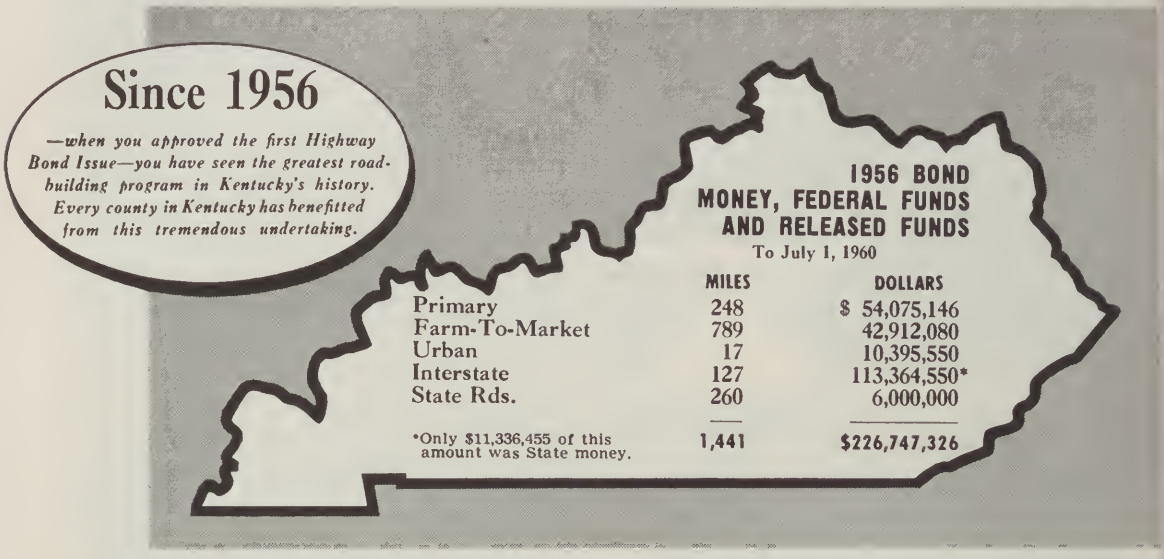
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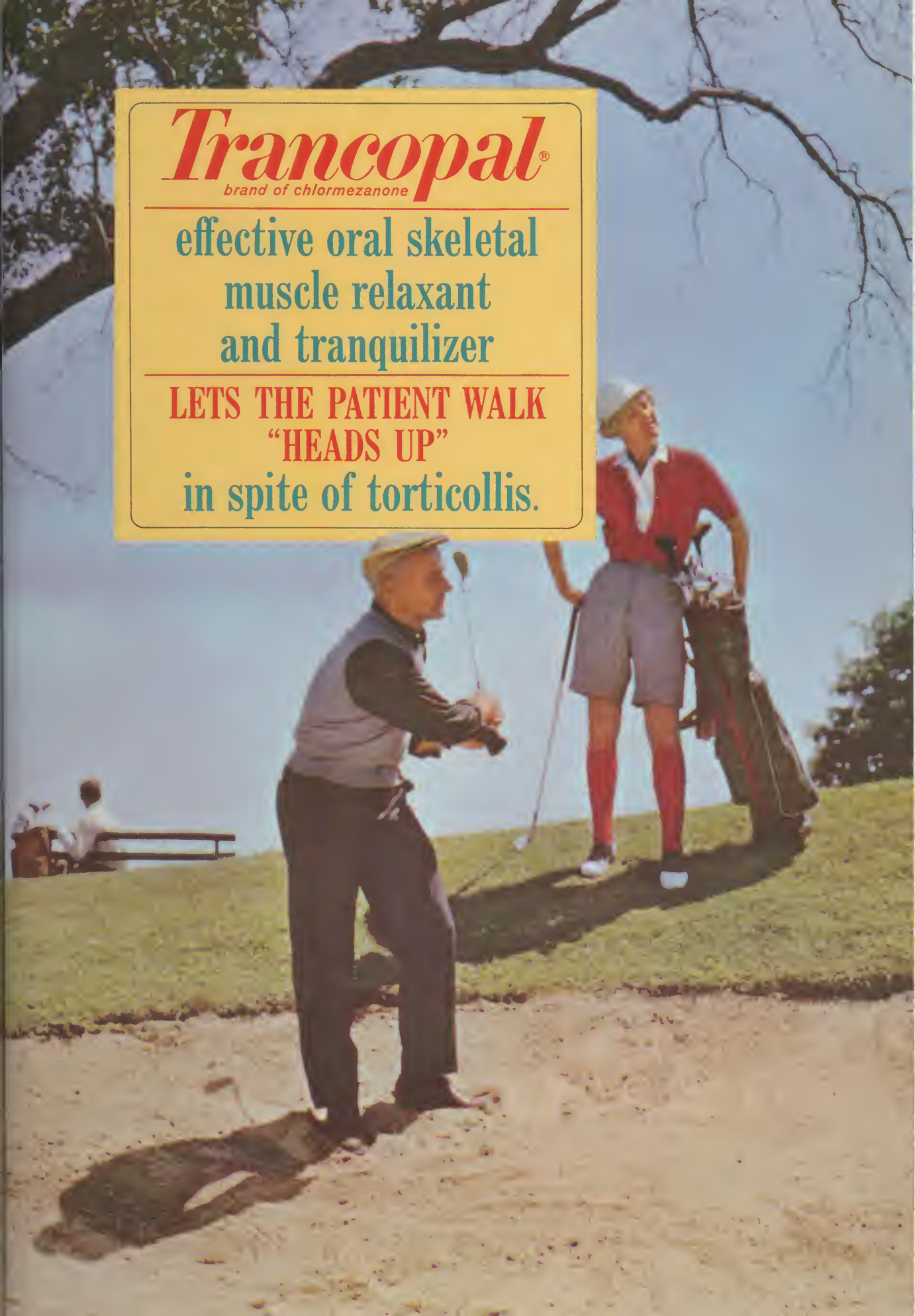
In all grades of hypertension, Serpasil may be used as a background agent. By permitting lower dosage of more potent antihypertensives, Serpasil minimizes the incidence and severity of their side effects.

CIBA
SUMMIT, N. J.

*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955. /2830M8

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1. Ganz, S. E.: *J. Indiana* 52:1134, July, 1959. 2. Kearne *Current Therap. Res.* 2:12 1960. 3. Lichtman, A. L.: *Acad. Gen. Pract. J.* 4:28, O

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COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #64 (1959)—This patient was a 31 year old, married, white, gravida 6, para 5, whose last menstrual period was July 28, 1958; her expected delivery date by menses was May 5, 1959.

She consulted her private physician in her sixth month of this pregnancy. Physical examination revealed no abnormalities. Her past history was significant in that she had a history of moderate hemorrhage with her last two deliveries. She was seen prenatally three times for this pregnancy with no abnormalities.

MONTH OF PREGNANCY

	1	2	3	4	5	6	7	8	9			
									1	2	3	4
Blood Pressure						120	118	120				
						80	78	80				
Weight						134	139	140				
Urine												

Rh + ; 11 gram Hb ; VDRL non-reactive April '59

Labor began spontaneously and she was admitted to the hospital at 10 P.M., May 6. She received 100 mg. Demerol analgesia; the time of administration was not stated. Two minims of pitocin were given around midnight. She delivered approximately an hour and 15 minutes later in good condition without a precipitate labor and without bleeding. The second stage was 30 minutes with the spontaneous delivery of a 7 lb. 7 oz. girl under open drop ether. The third stage lasted 30 minutes. At 1.25 A.M., approximately 15 minutes following the delivery and after the patient had been returned to her room, the body of the uterus was boggy and she had excessive bleeding.

The ergotrate was repeated intravenously 15 minutes after the initial injection that was given with the delivery of the placenta. As she continued to bleed in spite of this, intravenous pitocin was given and she was typed and cross matched. The ergotrate was repeated. The fundus remained firm with no bleeding for approximately 30 minutes, when the hemorrhage again ensued with a blood pressure of 70/50. Approximately one hour after delivery the blood transfusion was started.

An obstetrical consultant was called and saw the patient at 3 A.M., approximately two hours after she delivered. She was taken to the delivery room. Her blood pressure was 74/54 with a rapid pulse; she appeared pale and bled out. She was reanesthetized with ether and examined; no lacerations of the vagina or cervix were seen. The uterus was manually explored and found to be intact. Although the uterine cavity was packed she continued to bleed through the packing. Blood was drawn to check the fibrinogen index. More blood started at 3:40 A.M. No blood pressure was obtained at 4 A.M. and at this time it was also noted that the blood drawn one hour prior had not clotted.

Although the usual conditions that result in afibrinogenemia were not present in this case, one unit of fibrinogen was given under pressure and two more were ready, but the patient suddenly ceased to breathe. There was no palpable heart beat around 4 A.M. and adrenalin injection into the heart plus artificial respiration were without avail. She died at 5 A.M., 3½ hours postpartum.

An autopsy was performed with no significant findings. The uterus was normal, no lacerations were found. Gross and micoscopic sections of the lungs showed foci of atelectasis.

Cause of death on the certificate was exsanguinating hemorrhage postpartum.

Comment

The Committee felt this was a direct obstetrical death, probably due to afibrinogenemia, the stated cause.

Certain features of the described management have played a role in the unfortunate outcome. First the patient received two minims of pitocin. She delivered about 1½ hours later in what was described as good condition, without a precipitate labor or any bleeding. The above dose was larger than is usually considered safe. An occasional patient may prove sensitive and have a tetanic contraction resulting in either a laceration of the cervix with injury or death of the infant. In addition there is the possibility of damage to the birth canal.

The second stage of thirty minutes in a multipara was questioned in light of the total labor of only one and a half hours. The patient was treated promptly with the onset of the vaginal bleeding. Blood was given, the oxytocics repeated and the patient reexamined for possible lacerations of the birth canal and uterus not previously noted.

The autopsy in this case offered no explanation for the cause of the afibrinogenemia, but it did confirm the absence of an undetected laceration of the birth canal or uterus. An additional value of giving intravenous fluids to a patient postpartum is that the vein is accessible if it is needed suddenly.

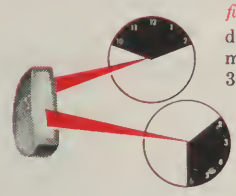


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Indications: nasal and paranasal congestion, sinusitis, postnasal drip, upper respiratory allergy.

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Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides:
½ the formulation of the Triaminic Tablet.
Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

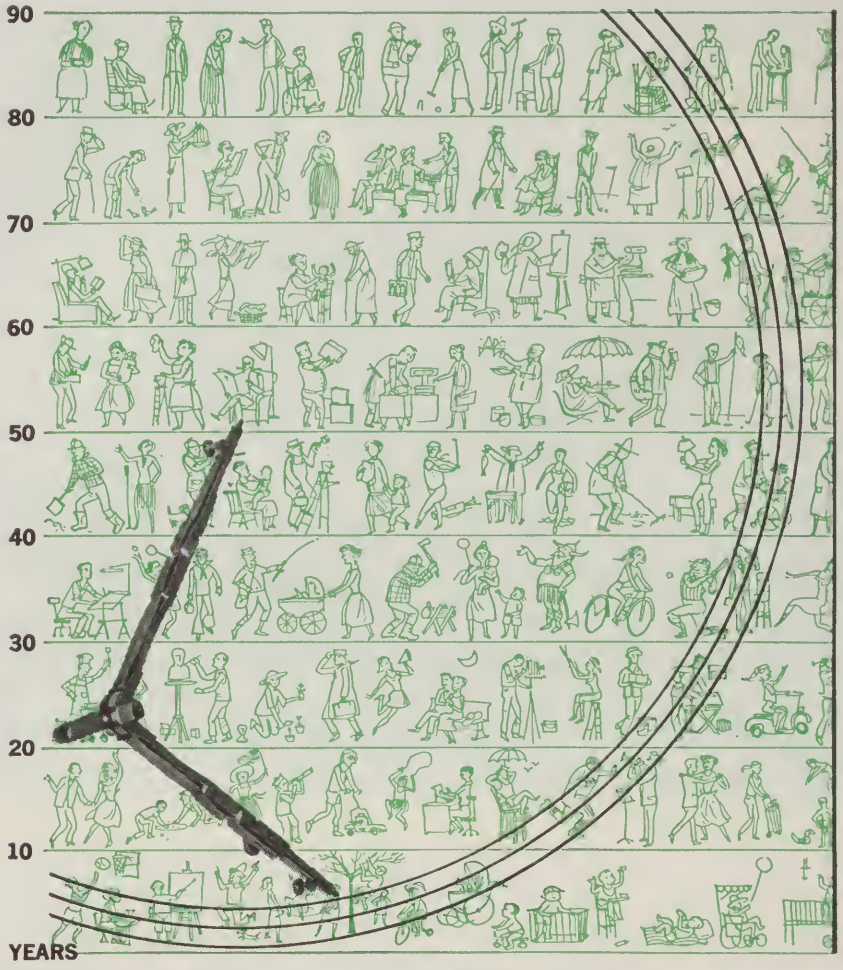
Each tsp. (5 ml.) of Triaminic Syrup provides:
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Dosage (to be administered every 3 or 4 hours):
Adults – 1 or 2 tsp.; *Children 6 to 12* – 1 tsp.;
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Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules. Prescription only.

Complete bibliography available on request.

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PUBLIC HEALTH PAGE

Chemotherapy

A Public Health Measure Against Tuberculosis

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health Commonwealth of Kentucky*

A THREE-DAY MEETING at Arden House, Harriman, N.Y., last December brought together eighteen national leaders in public health and tuberculosis control. Out of this meeting, known as the Arden House Conference, came twelve specific recommendations and a challenge to the people of the United States to wipe out tuberculosis in this country.

For the most part, these suggestons were reaffirmations of well known tuberculosis control practices. However, the major recommendation—chemotherapy used as a public health measure—offered an entirely new approach.

During the past eight months the Arden House Conference has engendered much interest and enthusiasm both pro and con. In a recent publication of the Department of Health, Education, and Welfare,, Dr. Edward T. Blomquist, Chief, Tuberculosis Program, U.S. Public Health Service, has summarized his thoughts concerning the major recommendation of the conference. His comments are briefed here.

The unique aspect of this recommendation lies in its emphasis on chemotherapy primarily as a public health tuberculosis-control measure (as well as for the benefit of the individual patient) with all the connotation of community mobilization and control by public health authorities that this new concept implies. Chemotherapy can reverse the infectiousness of most tuberculosis patients within three to five months. Most patients, under chemotherapy, do just as well whether they are ambulant or on bed rest. Therefore, the patient need no longer get all of his treatment in a hospital and indeed many patients can be satisfactorily treated without ever going to one.

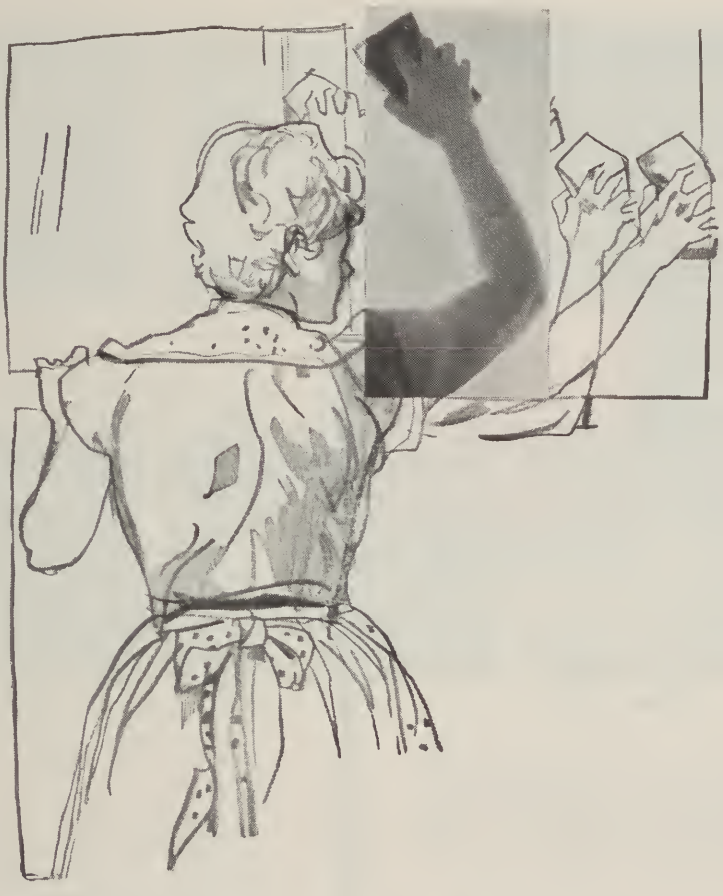
In view of these facts, a quite reasonable assumption would be that tuberculosis patients now can be treated more economically in the community. The problem is that while out-patient treatment can be adequate it often is not. Health departments have not been staffed and equipped to take care of large numbers of tuberculosis patients. The declining death rate and the closing of hospitals have been interpreted by the public as evidence that tuberculosis services in general can be cut back and health departments have considerable difficulty keeping the services they have.

Tuberculosis control as far as treatment is concerned may be divided into three stages. Definitions of these stages and a recommended program approach for each are summarized in the following table:

Stage	Definition	Program Approach
1.	Community unable to provide adequate Rx for a significant proportion (25% or more) of known active cases.	a. Bring more cases to Rx using all community resources available. b. Use of prophylactic Rx in selected groups. c. De-emphasize casefinding except for followup of close contacts and complete diagnosis of "suspects."
2.	Adequate Rx provided for high proportion of known active cases (75-80%). Most contacts being examined and definitive diagnosis good.	a. Try to reach persons who have previously had active disease but who have been inadequately treated. b. Prophylaxis for recent tuberculin converters. c. Extension of casefinding beyond contacts and suspects.
3.	Community has found most of its active cases and certain categories of inactive cases and brought them to appropriate treatment.	a. Extension of casefinding to find and treat persons at high risk such as tuberculin reactors with suspicious chest X-rays.

New treatment services, either in the health department or in other community facilities, are rarely considered.

Tuberculosis specialists are in short supply since



To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

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Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
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Helps prevent infection! Safely cleans from skin all types of foreign soils, tars, grease, paint, crater compounds, creosote, printing inks, rubber and gasket cements and other foreign "toughies."

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May be used "with or without" water on face, hands and other parts of the body. Easily rinsed off with water.

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PUBLIC HEALTH PAGE

(Continued from Page 1236)

few young physicians choose to go into this special In a great many communities, therefore, the two-thi of tuberculosis patients who are not under the care a private physician are not getting much benefit fr the drug treatment that could make them well a remain as much of a potential problem in pu health as were the patients on hospital waiting lists pre-chemotherapy days.

The solution, it would appear, lies in changing order of our tuberculosis-control thinking, plac treatment at the center so that it can become a m more effective public health measure than it has b so far. Treatment for tuberculosis is a public hea activity whether it is done by the private physician, health department or the tuberculosis hospital, though it is the health department who has the le responsibility for tuberculosis control. Accepting t interpretation of the major recommendation of conference, the facility with which it can be carr out will vary widely in different areas and will dep greatly upon the adequacy of present tuberculo control programs.

Making use of this "three-stage" concept impl knowledge of the current status of tuberculosis cas Kentucky is still at stage I with less than 70% of known active cases under chemotherapy. Accord to the Arden House concept, our main concern sho be an intensive effort to bring more cases to tre ment.

Essential to such a therapy oriented approach is provision of adequate outpatient care supervised competent chest physicians strongly supported satisfactory laboratory and X-ray facilities and ready availability of drugs for all. Especially for 50% of patients who do not live in urban centers, s an approach to tuberculosis control calls for care planning and coordination at the state level so t local community resources may be supplemented statewide resources.

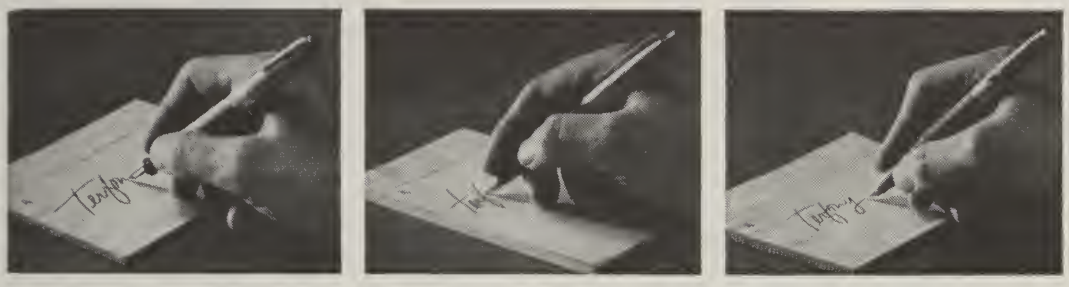
New Hospital Opens In Louisvill

The new $6,250,000 Methodist Evangelical Hospi in Louisville was formally opened in ceremonies 7 p.m. Sunday, September 4. First patients were mitted on September 6.

The hospital has 300 beds, 130 of which w opened. The remaining 170 beds will be oper about 20 at a time as the need arises, said P Ahlstedt, hospital administrator.

Kidney Seminar Set In Virginia

A seminar on kidney disease, November 25 and is announced by the Southeastern Region of the C lege of American Pathologists and the Virginia Soci of Pathologists. The two-day meeting will be held Richmond, Va. Slide sets for the seminar may be p chased for $15 each by writing to: G. T. Mann, M. Professor of Forensic Pathology, P. O. Box Medical College of Virginia, Richmond 19, Va.



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when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

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Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.



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Complete information on indications, dosage and precautions is included in the circular accompanying each package.

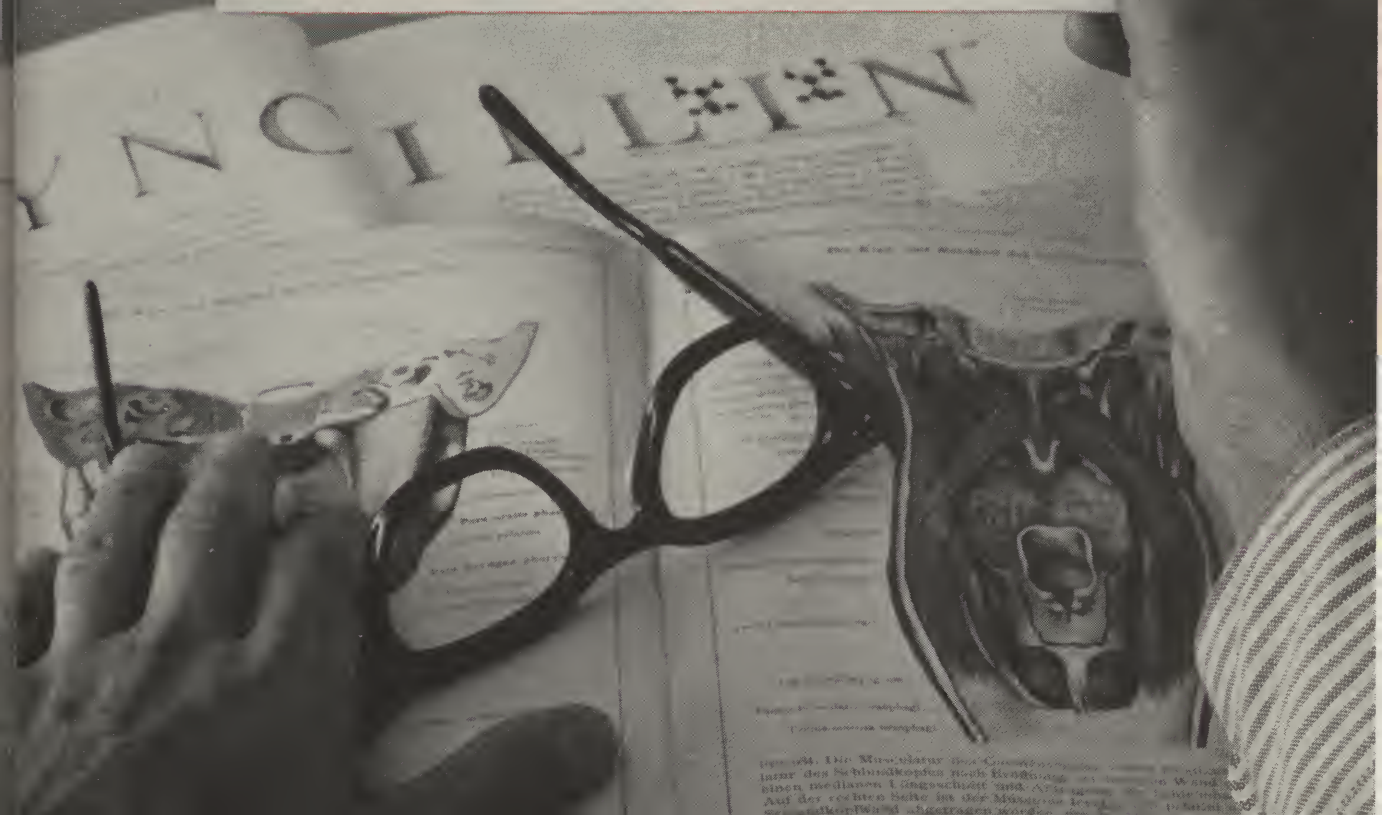
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W. M. 24-year-old-male. Admitted with sore throat which had progressed rapidly in severity for 24 hrs. Temp. 104.4. Pulse 110. Acute pharyngitis and enlarged, red, bulging tonsils covered with pus. Throat culture revealed beta hemolytic strep. Patient given 500 mg. SYNCILLIN t.i.d. Within 24 hrs., fever terminated by crisis with marked relief of local signs and symptoms. After 5 days, infection was cured.

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from the files of
tol Laboratories'
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new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy



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Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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helping the hypertensive to help himself...

THEOMINAL® R.S.

(Theominal with Rauwolfia serpentina)

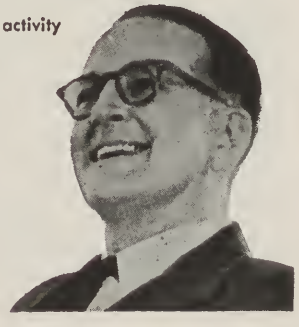
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Theobromine	**320 mg.**
Luminal®	**10 mg.**
Rauwolfia serpentina alkaloids (alseroxylon)	**1.5 mg.***

DOSAGE: The usual dose of Theominal R.S. is 1 tablet two or three times daily. When improvement has been maintained for a time, the dose may be reduced or medication suspended occasionally until resumption is indicated.

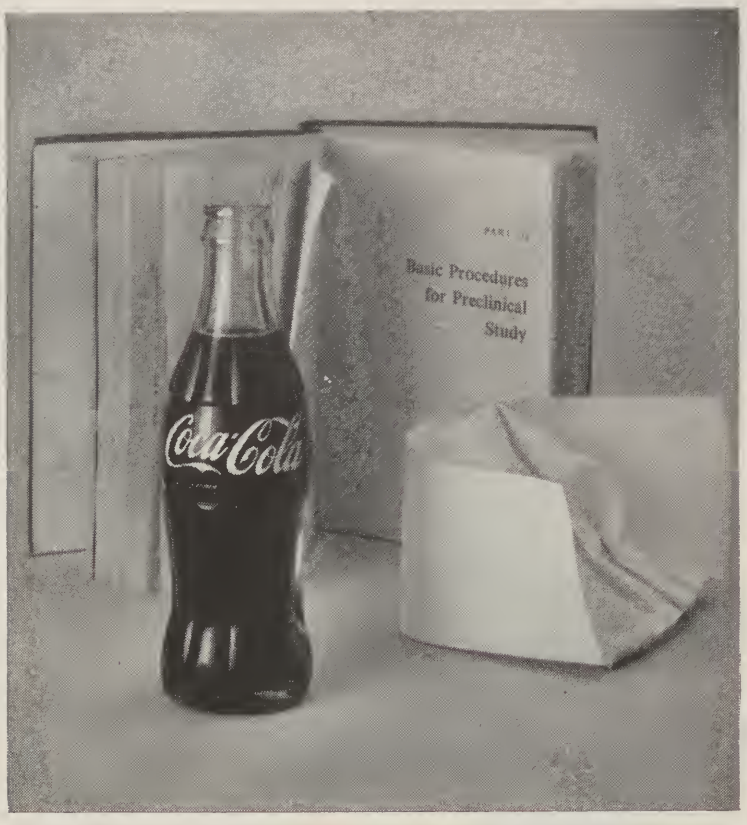
SUPPLIED: Bottles of 100 and 500 tablets.

* = 0.3 mg. reserpine in activity



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the unyielding hours,
a welcome
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often puts things
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Dosage: One tablet one-half to one hour before each meal.

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Calurin®, calcium acetylsalicylate carbamide equivalent to aspirin 300 mg. This is the freely-soluble calcium aspirin that minimizes local irritation, chemical erosion, gastric damage. High, fast blood levels.

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	Term
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J. Vernon Pace, 333 Broadway, Paducah (Alternate)	Jan. 1, 1960-Dec. 31, 1961
Robert C. Long, 806 Heyburn Building, Louisville	Jan. 1, 1959-Dec. 31, 1960
George P. Archer, Prestonsburg (Alternate)	Jan. 1, 1959-Dec. 31, 1960

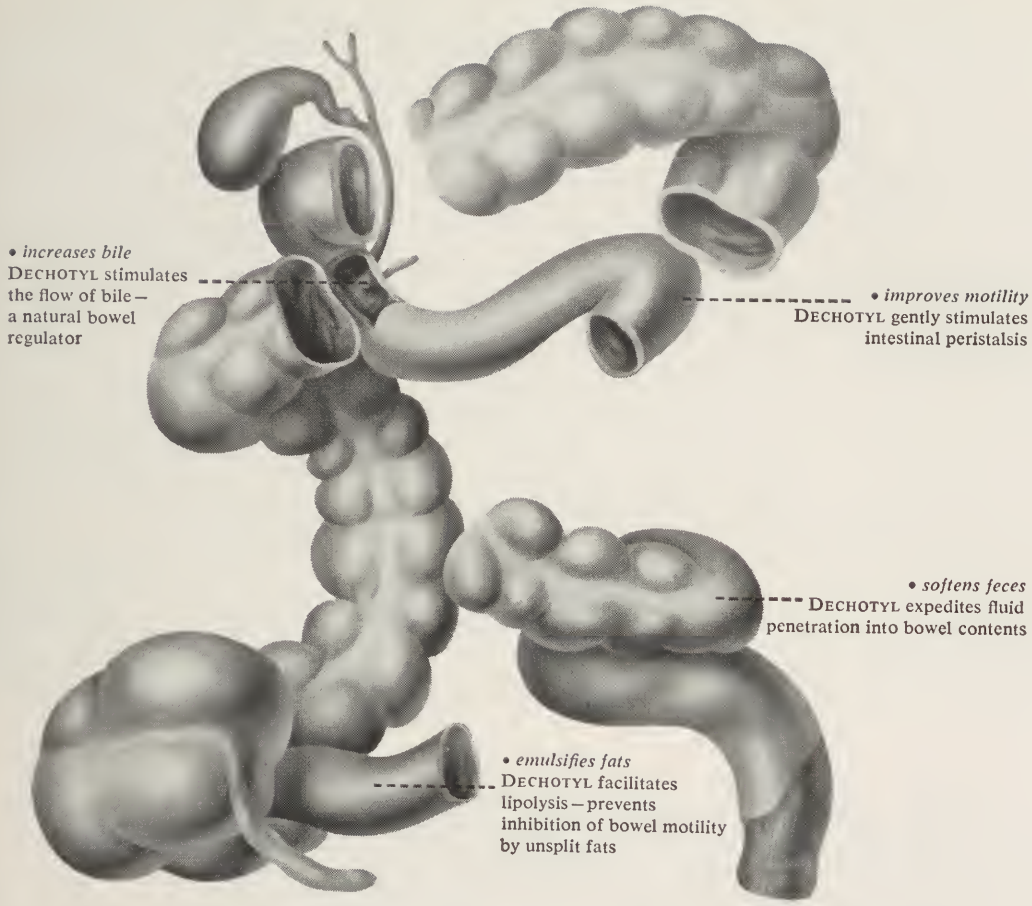
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Journal of the Kentucky State Medical Association, October, 1960

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UNDER MEDICINE

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4,860 CULTURES... 74% SENSITIVE TO CHLORO

In a study of the sensitivity of various clinically important bacteria to six common antibacterial substances, Goodier and Parry[1] report "...a greater proportion of the individual strains within the various genera sensitive to chloramphenicol."

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References: (1) Goodier, T. E. W., & Parry, W. R.: *Lancet* 1:356, 1959. (2) Modarress, Y.; Ryan, R. J., & Francis, Sr. C.: *J. M. Soc. New Jersey* 57:168, 1960. (3) Petersdorf, R. G., *et al.*: *Arch. Int. Med.* 105:398, 1960. (4) Rebhan, A. W., & Edwards, H. E.: *Canad. M.A.J.* 82:513, 1960. (5) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960. (6) Olarte, J., & de la Torre, J. A.: *Am. J. Trop. Med.* 8:324, 1959. (7) Berle, B. B., *et al.*: *New York J. Med.* 59:2383, 1959. (8) Fisher, M. W.: *Arch. Int. Med.* 105:413, 1960.

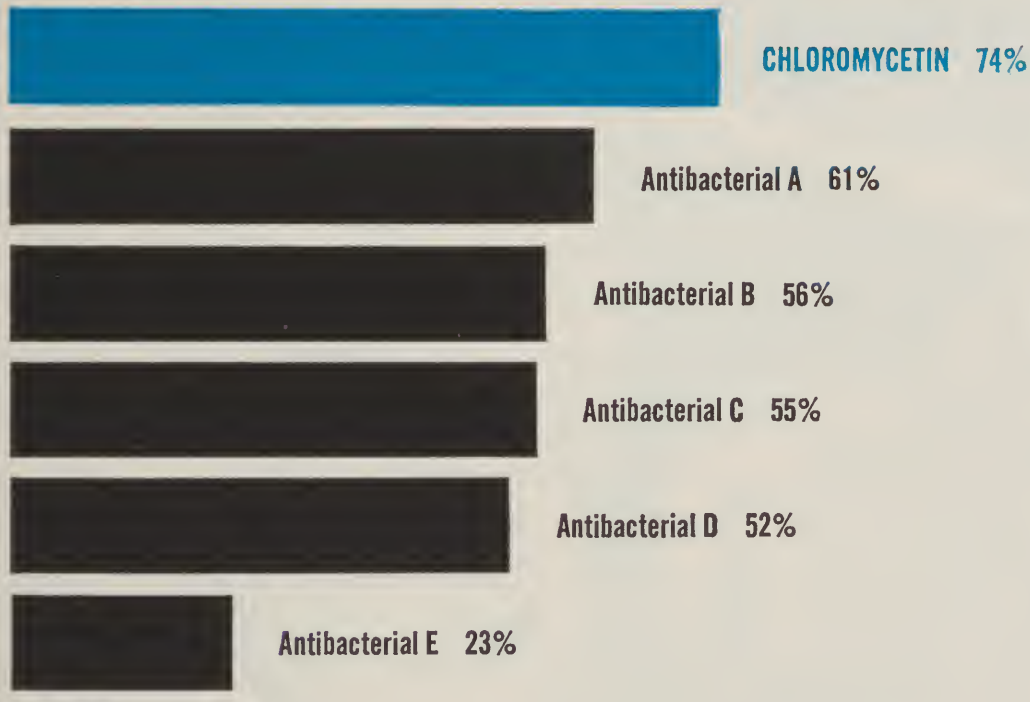
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*Adapted from Goodier & Parry[1]

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CLINICAL REMISSION IN A "PROBLEM" ARTHRITIC

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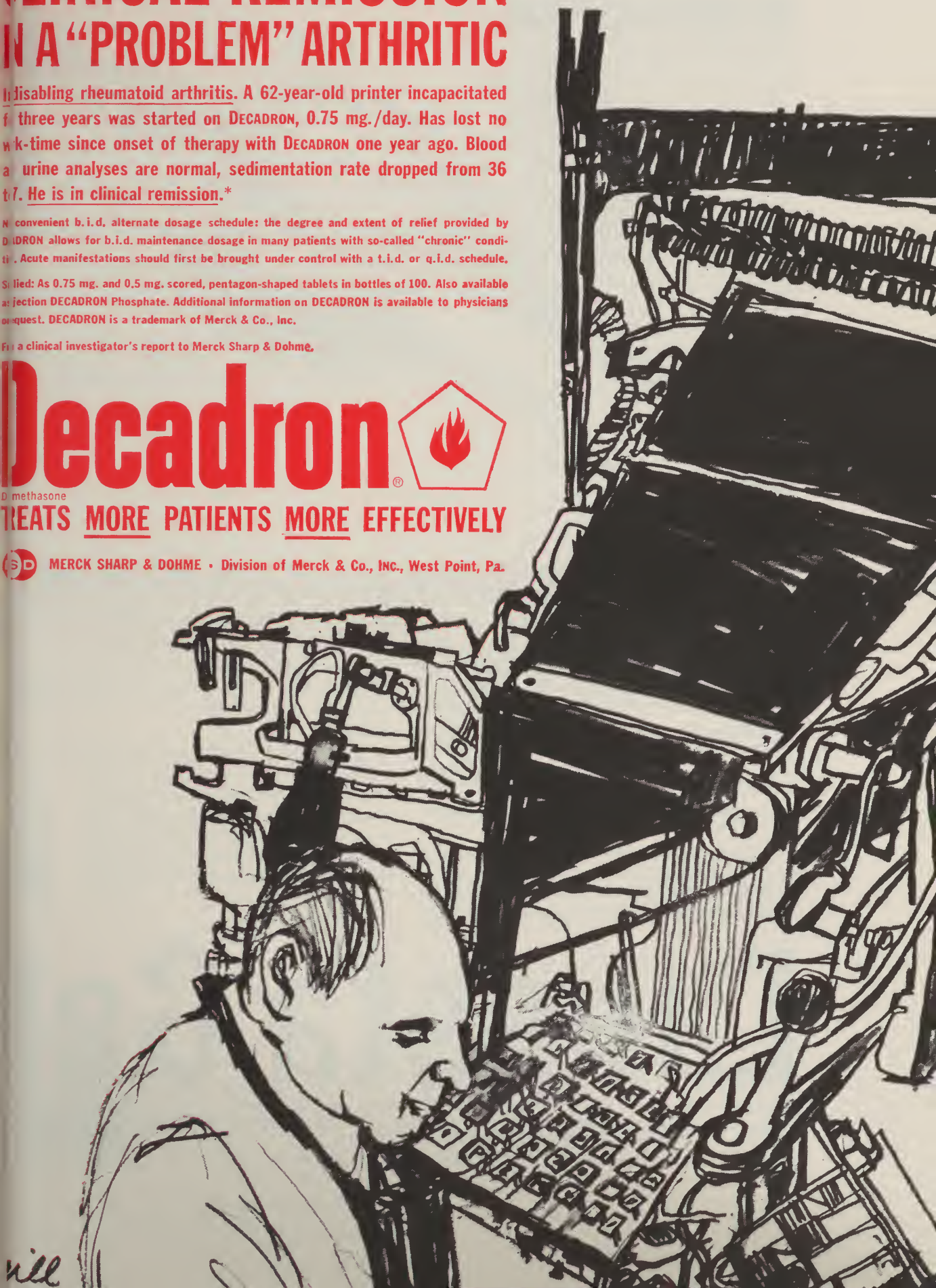
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Is potassium excretion a problem with NaClex?

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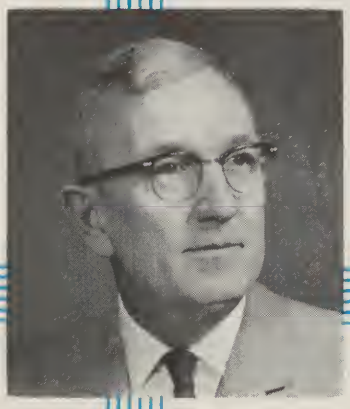
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References: 1. Ford, R. V., Cur. Therap. Res., 2:51, 1960. 2. Pitts, R. F., Am. J. Med., 24:745, 1958.

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MESSAGE FROM THE PRESIDENT

Not Officers – But Leaders

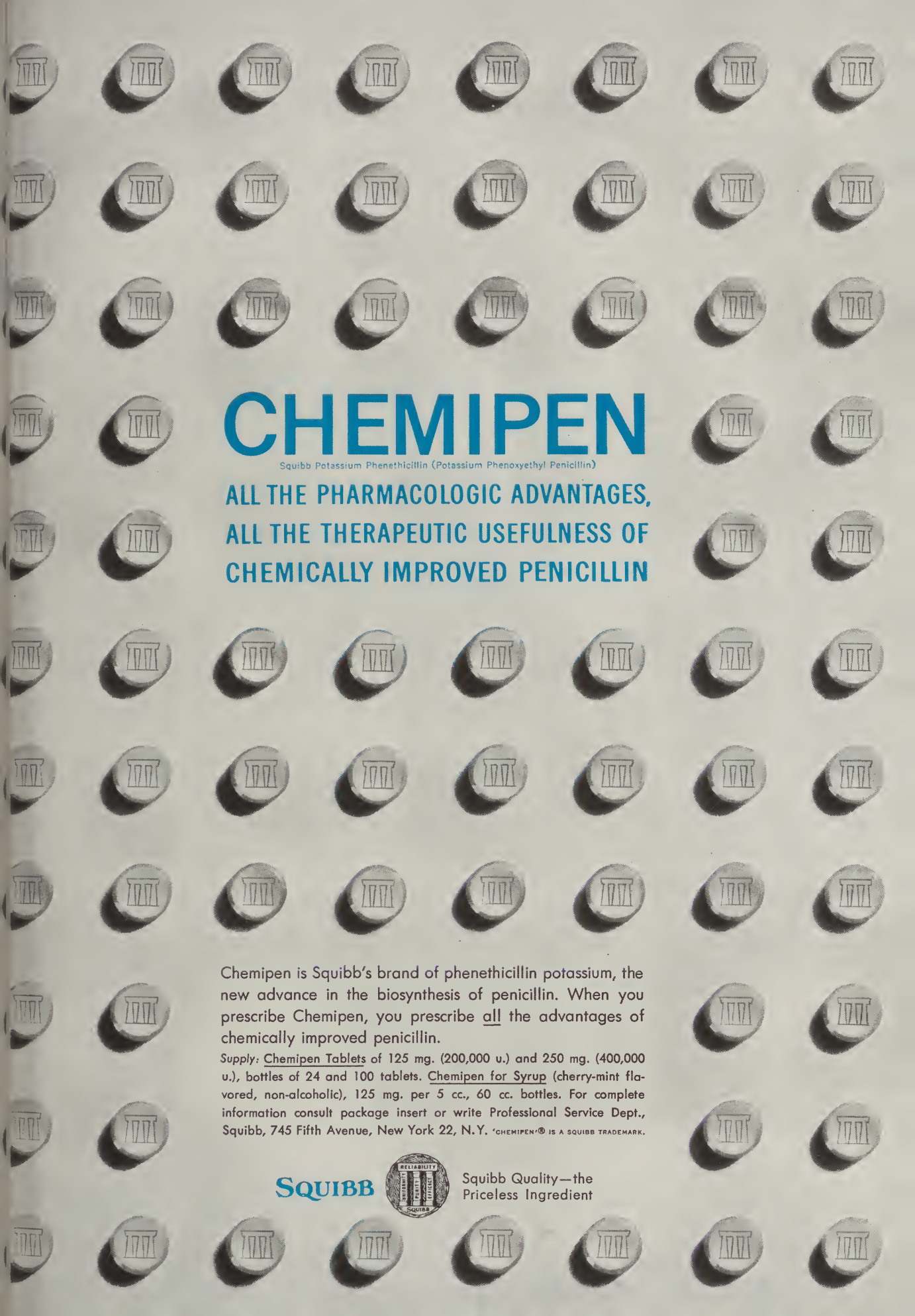
THE majority of county medical societies elect their officers for the coming year in November and December. The president, the secretary and the delegates are the key men among the society officers. They will lead the way to a successful active year or the society simply passes another one.

In many societies the president reaches his position through seniority while the office of secretary is conferred on the youngest member of the society. This may be a happy combination, but often seniority brings a lack of drive and interest to the presidency and youth brings enthusiasm but inexperience to the secretaryship.

The members of the House of Delegates perform an important part in the function of the State Association. They should serve a term of office of sufficient length that they are familiar with the machinery of the House and are informed and effective representatives of their local societies. The delegates also may be chosen because they plan to attend the state meeting. They should be chosen as carefully as the other officers.

These are years when the pattern of medical practice is changing and when it may change radically quite suddenly. These are times when each society should have the best leadership that is possible from its membership. Consider carefully the experience, wisdom, interest and capabilities of your candidates for these important offices and put in office men who will do well whatever comes to hand.

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THE INSURANCE PAGE



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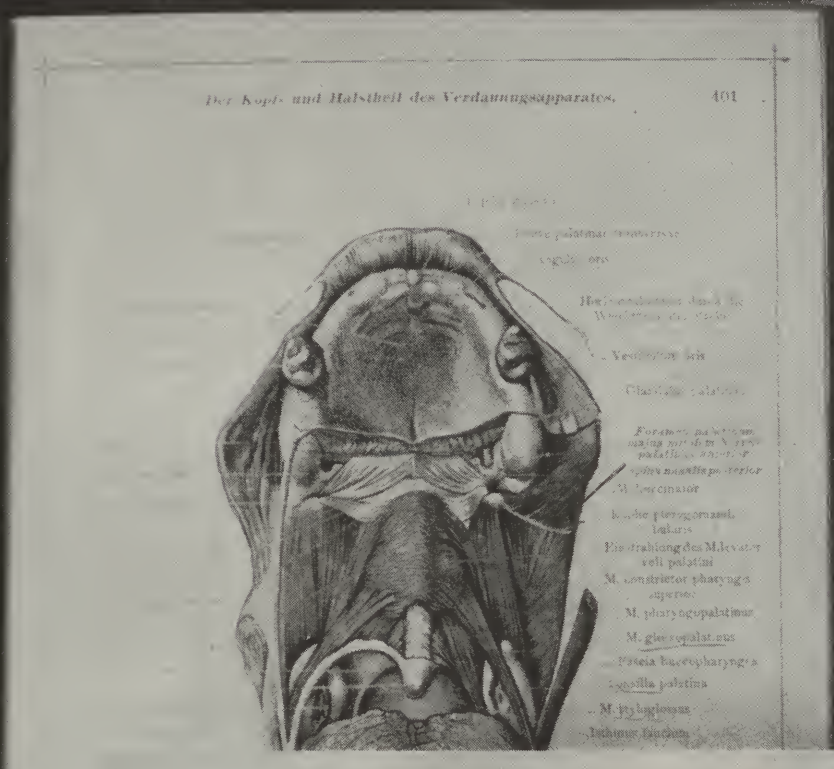
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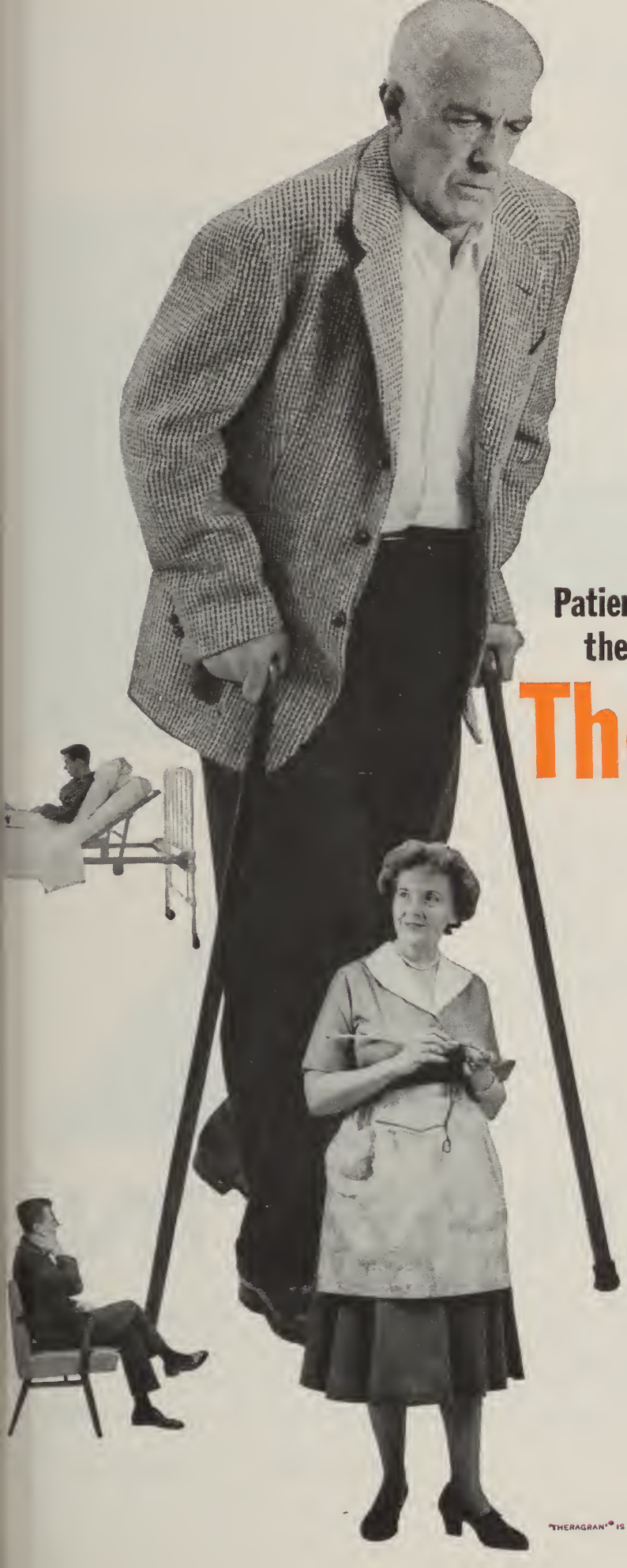
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in cardiac disease[23,26,29,38,41]
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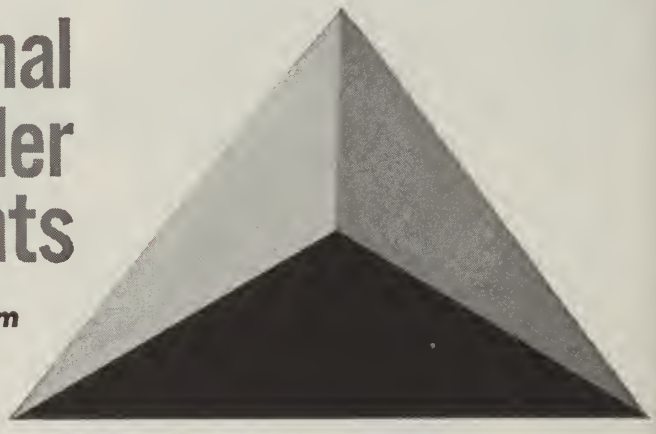
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3-dimensional support for older patients



BOLSTERS... ▲ *tissue metabolism*
▲ *interest, vitality*
▲ *failing nutrition*

NEW

1 small capsule every morning

GEVRESTIN®

Geriatric Vitamins-Minerals-Hormones-d-Amphetamine Lederle

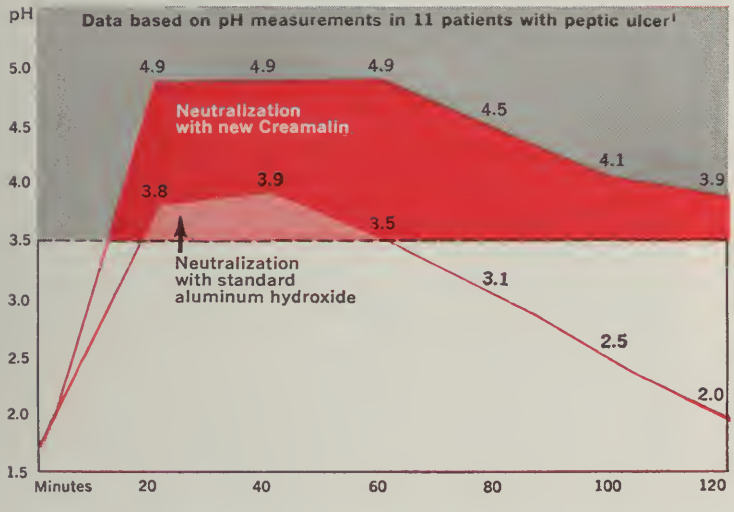
Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental Iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

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At the site of peptic ulcer



Following determination of basal secretion, intragastric pH was continuously determined by means of frequent readings over a two-hour period.



neutralization is much faster and twice as long with

New CREAMALIN® ANTACID TABLETS

New proof in vivo[1] of the much greater efficacy of new Creamalin tablets over standard aluminum hydroxide has now been obtained. Results of comparative tests on patients with peptic ulcer, measured by an intragastric pH electrode, show that new Creamalin neutralizes acid from 40 to 65 per cent faster than the standard preparation. This neutralization (pH 3.5 or above) is maintained for approximately one hour longer.

New Creamalin provides virtually the same effects as a liquid antacid[2] with the convenience of a tablet.

Nonconstipating and pleasant-tasting, new Creamalin antacid tablets will not produce "acid rebound" or alkalosis.

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles of the powder offer a vastly increased surface area for quicker and more complete acid neutralization.

Dosage: Gastric hyperacidity — from 2 to 4 tablets as necessary. Peptic ulcer or gastritis — from 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth. **How supplied:** Bottles of 50, 100, 200 and 1000.

1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

Winthrop LABORATORIES
New York 18, N. Y.

for peptic ulcer ■ gastritis ■ gastric hyperacidity

"I'm sending this urine specimen from the patient with pyelitis to the lab. What'll I order while I'm waiting for the findings?"

"I'd use AZOTREX. The azo dye will give her quick symptomatic relief. The sulfa-tetracycline combination is likely to hit the common urinary pathogens. If she doesn't respond, then switch to something else when you get the sensitivity data."



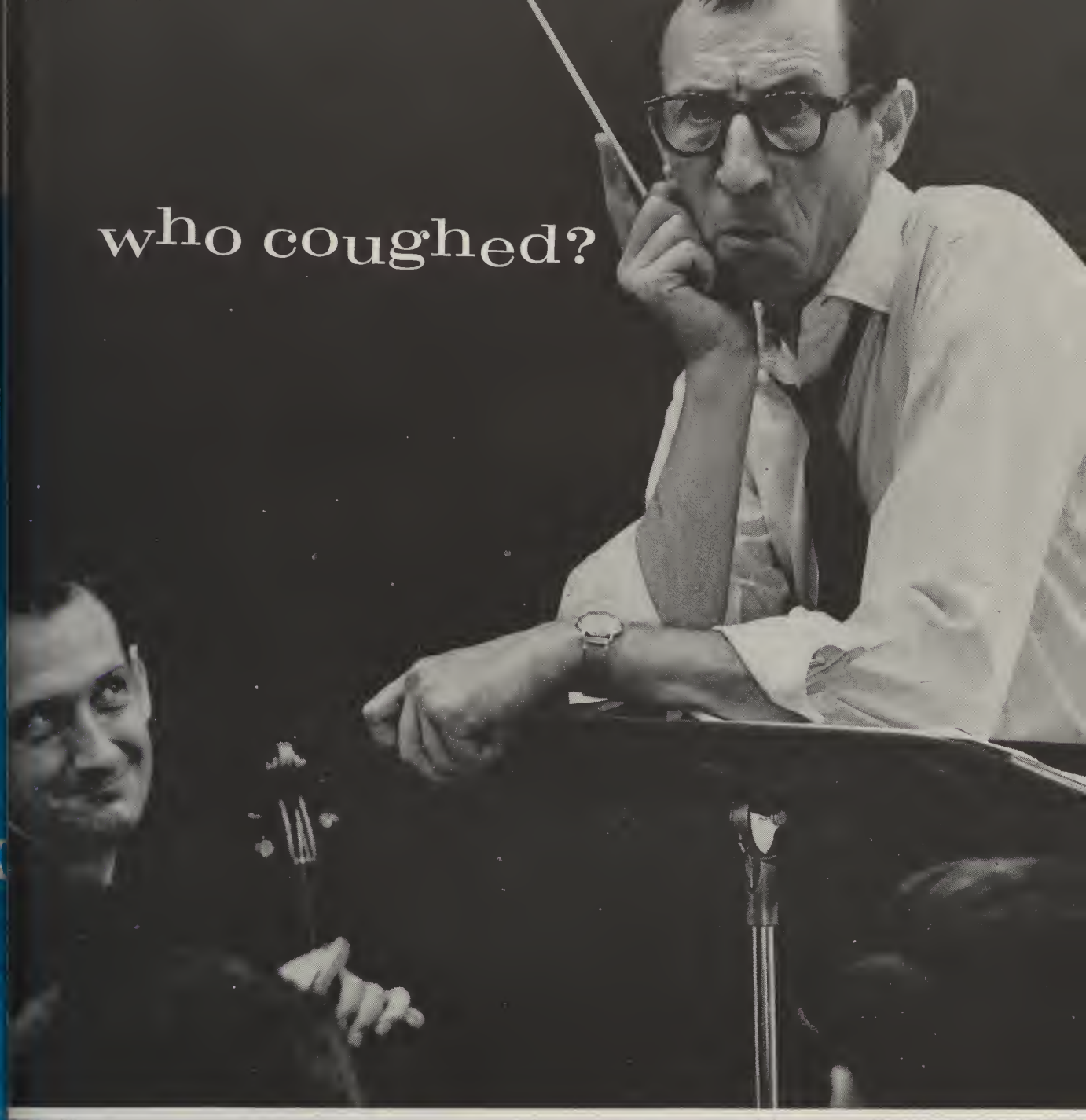
Azotrex

Each AZOTREX capsule contains: TETREX® (tetracycline phosphate complex) equivalent to tetracycline HCl activity... 125 mg.; sulfamethizole 250 mg.; phenylazo-diamino-pyridine HCl... 50

Supply: Bottles of 24 and 100.

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WHENEVER COUGH THERAPY IS INDICATED

HYCOMINE®

Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative | antihistamine
decongestant | expectorant

▪ relieves cough and associated symptoms in 15-20 minutes ▪ effective for 6 hours or longer ▪ promotes expectoration ▪ rarely constipates ▪ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains:

Hycodan®		
Dihydrocodeinone Bitartrate	5 mg.	6.5 mg.
(Warning: May be habit-forming)		
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law permits oral prescription.

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WASHINGTON NEWS DIGEST

Washington, D. C.—Representatives of the medical and health professions, the Federal Government and national civic groups are cooperating in development of a program for starting the general use of the Sabin live-virus poliomyelitis vaccine next year.

Shortly after clearing the Sabin vaccine for general use, Leroy E. Burney, M.D., Surgeon General of the Public Health Service, asked 23 non-government organizations to designate members to serve on a Surgeon General's Committee on Poliomyelitis Control.

An agenda committee met with PHS officials in Atlanta October 11 and 12 and drafted a basic agenda for a meeting of the Control committee in mid-winter. At the Atlanta meeting, preliminary consideration also was given to administrative and technical problems involved in use of the live-virus vaccine developed by Albert B. Sabin, M.D., of Cincinnati.

Six Groups On Committee

The agenda committee was made up of representatives of the American Medical Association, American Academy of General Practice, American Academy of Pediatrics, Association of State and Territorial Health Officers, Children's Bureau and the National Foundation.

The Sabin vaccine is not expected to be available in substantial quantities before mid-1961.

The chief question is whether the vaccine—which is given orally in the form of pills, liquid or candy—will be administered on individual or mass community basis. The PHS special committee that recommended approval of the oral vaccine said that the community basis would be better.

Concern Expressed

"Because of the unique nature of live poliovirus vaccine, with its capacity to spread the virus in a limited manner to non-vaccinated persons, the committee cannot make recommendations for manufacture without expressing concern about the manner in which it may be used," the special committee said.

"The seriousness of this responsibility can be illustrated, for example, by the known potentiality of reversion to virulence of live poliovirus vaccine strains, and the possible importance of this feature in the community if the vaccine is improperly used.

For example, the vaccine has been employed largely in mass administrations where most of the susceptibles were simultaneously given the vaccine, thus permitting little opportunity for serial human transmission; or, it has been administered during a season of the year when wild strains have usually shown limited capacity for spread. This experience should provide the basis for developing useable practices for the U.S.A."

The special committee also said attention should be given to administration to special groups, such as very young children, pregnant women and susceptible adults.

"Even more important is the planned continuation of this program as long as necessary to achieve and maintain the required results," the committee said.

The committee was headed by Roderick Murray, M.D., of the National Institutes of Health. Its other members were four M.D.'s and one Ph.D., all of whom were connected with universities except for one M.D. from the PHS's Communicable Disease Center at Atlanta.

Use of Both Vaccines Predicted

Neither the committee nor Doctor Burney anticipated that the live virus vaccine would replace the killed-virus Salk vaccine used since April, 1955.

"It appears probable that only a unified national program which utilizes each of the available types of vaccine to its best advantage can accomplish the total prevention of outbreaks." the committee said.

Julian P. Price, M.D., of Florence, S. C., Chairman of the AMA's Board of Trustees, predicted the live-virus vaccine "will be one more powerful weapon against an ancient and crippling disease." He said that physicians "have conscientiously pushed immunization with the Salk vaccine and now, with this new vaccine, the profession is hopeful that even better results can be achieved."

* * *

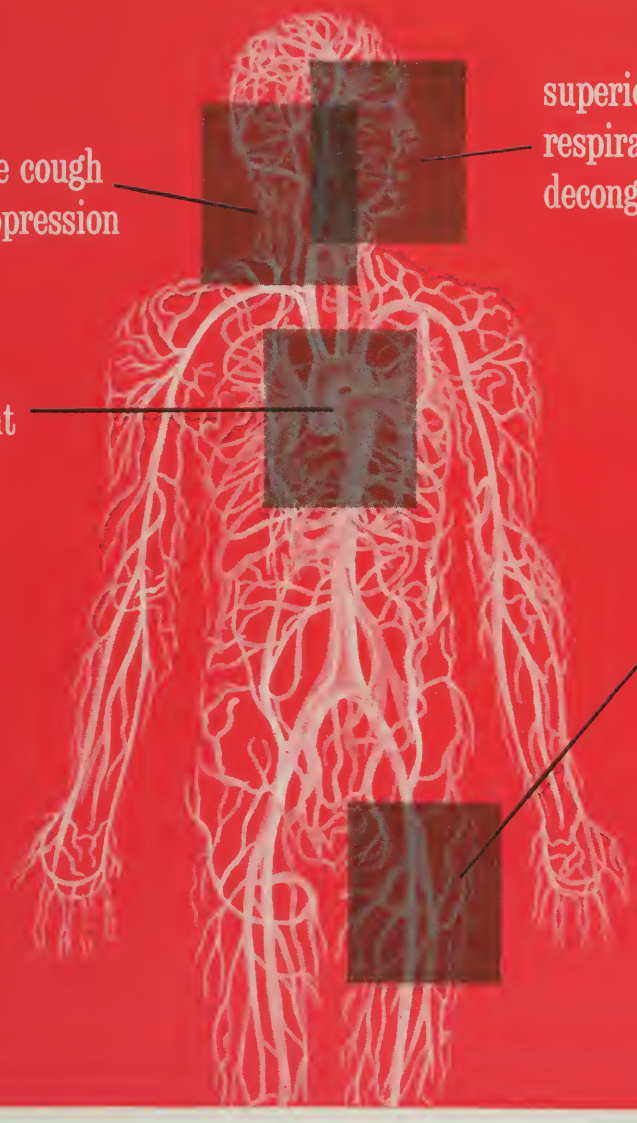
FIVE STATES WERE READY soon after the effective date of October 1 to submit plans for participation in the federal-state program of health care for the needy and near-needy aged persons which recently was enacted into law. The states were Arkansas, Michigan, New Mexico, Oklahoma and Washington.

As of early October, another 25 states were preparing to consider legislation to set up such a program or had indicated a willingness to proceed without new legislation. They were Alabama, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Montana, Nevada, New Jersey, North Dakota, North Carolina, Ohio, Pennsylvania, Rhode Island, Utah, West Virginia, Virginia and Wyoming.

Arthur S. Flemming, Secretary of Health, Education and Welfare, urged all states to take part in the

(Continued on Page 1366)

for relief from the total cold syndrome...



Tussagesic*

timed-release tablets / suspension

Each Tussagesic timed-release Tablet provides:

TRIAMINIC®	50 mg.
DORMETHAN (brand of dextromethorphan HBr)	30 mg.
TERPIN HYDRATE	180 mg.
APAP (acetaminophen)	325 mg.

Dosage: *Adults and children over 12* — one tablet in the morning, midafternoon and at bedtime. Each tablet should be swallowed whole to preserve the timed-release action.

Each tsp. (5 ml.) of Tussagesic Suspension provides:

TRIAMINIC®	25 mg.
DORMETHAN (brand of dextromethorphan HBr)	15 mg.
TERPIN HYDRATE	90 mg.
APAP (acetaminophen)	120 mg.

Tussagesic Suspension is especially suited for children and for adults who prefer liquid medication; it is pleasantly flavored, non-narcotic and non-alcoholic.

Dosage (to be taken every 3 or 4 hours): *Adults and children over 12* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

* TRADEMARK

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska



FIORINAL®

relieves pain, muscle spasm, nervous tension

rapid action · non-narcotic · economical

"We have found caffeine, used in combination with acetylsalicylic acid, acetophenetidin, and isobutylallylbarbituric acid, [Fiorinal] to be one of the most effective medicaments for the symptomatic treatment of headache due to tension."

Friedman, A. P., and Merritt, H. H.: J.A.M.A. *163*:1111 (Mar. 30) 1957.

Available: Fiorinal Tablets and New Form — Fiorinal Capsules

Each contains: Sandoptal (Allylbarbituric Acid N.F. X) 50 mg. (3/4 gr.), caffeine 40 mg. (2/3 gr.), acetylsalicylic acid 200 mg. (3 gr.), acetophenetidin 130 mg. (2 gr.).

Dosage: 1 or 2 every four hours, according to need, up to 6 per day.

SANDOZ



What's she doing that's of medical interest?

he's drinking a glass of pure Florida range juice. And that's important to er physician for several reasons.

How your patients obtain their vita-ins or any of the other nutrients found n citrus fruits is of great medical inter-st—considering the fact there are so any wrong ways of doing it, so many ubstitutes and imitations for the real hing.

Actually, there's no better way for his young lady to obtain her vitamin C han by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit among your young patients — and for that matter, your patients of any age — you'll be helping them to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus—watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

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Hydroflumethiazide • Reserpine • Protoveratrine A

An integrated multi-therapeutic antihypertensive, that combines in balanced proportions three clinically proven antihypertensives.

In each **SALUTENSIN** Tablet:

Saluron® (hydroflumethiazide)—a saluretic-antihypertensive	50 mg.
Reserpine—a tranquilizing drug with peripheral vasorelaxant effects	0.125 mg.
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Comprehensive information on dosage and precautions in official package circular or available on request.

BRISTOL LABORATORIES • Syracuse, New York

"...extraordinarily effective diuretic..."[1]

Efficacy and expanding clinical use are making Naturetin the diuretic of chaice in edema and hypertensian. It maintains a favarable urinary sadium-patassium excretian ratia, retains a balanced electralyte pattern, and causes a relatively small increase in the urinary pH.[2] Mare patent than ather diuretics, Naturetin usually pravides 18-haur diuretic actian with just a single 5 mg. tablet per day — ecanamical, ance-a-day dasage far the patient. Naturetin c̄ K — far added pratectian in thase special canditians predispasing to hypokalemia and far patients an lang-term therapy.

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References: 1. David, N. A.; Parter, G. A., and Gray, R. H.: Managraphs an Therapy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

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Naturetin c̄ K Squibb Benzydroflumethiazide with Potassium Chloride

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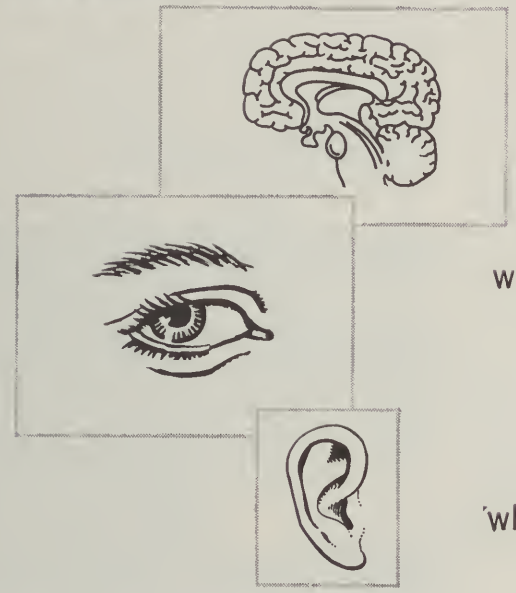


*NATURETIN c̄ K IS A SQUIBB TRADEMARK.



basic in the care of the aging

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when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*

when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

when voices begin to fade—*in loss of auditory acuity, in tinnitus*

Metalex® *cerebral stimulant/vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

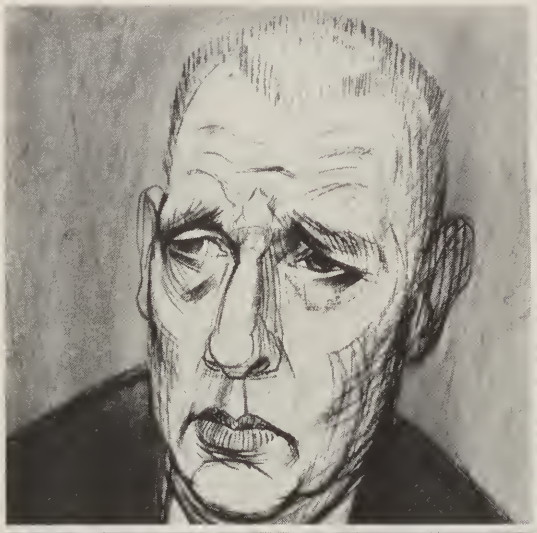
Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

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whenever depression complicates the picture

Tofrānil®
brand of imipramine HCl



hastens recovery

Geigy

In many seemingly mild physical disorders an element of depression plays an insidious etiologic or complicating role.

Because of its efficacy as an antidepressant, coupled with its simplicity of usage, Tofrānil is admirably adapted to use in the home or office in these milder "depression-complicated" cases.

It is always wise to recognize that depression may be an underlying factor...that Tofrānil may speed recovery in "hypochondriasis"; in convalescence when recovery is inexplicably prolonged; in chronic illness with dejection; in the menopausal patient whose emotional disturbances resist hormone therapy; and in many other comparable situations in which latent depression may play a part.

Detailed Literature Available on Request.

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Geigy, Ardsley, New York

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inner protection



Tain

(Triacetyloleandomycin, Triaminic® and Calurin®)

to contain the bacteria-prone cold

safe antibiosis

Triacetyloleandomycin, equivalent to oleandomycin 125 mg. This is the URI antibiotic, clinically effective against certain antibiotic-resistant organisms.

fast decongestion

Triaminic®, 25 mg., three active components stop running noses. Relief starts in minutes, lasts for hours.

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Calurin®, calcium acetylsalicylate carbamide equivalent to aspirin 300 mg. This is the freely-soluble calcium aspirin that minimizes local irritation, chemical erosion, gastric damage. High, fast blood levels.

TAIN brings quick, symptomatic relief of the common cold (malaise, headache, muscular cramps, aches and pains) especially when susceptible organisms are likely to cause secondary infection. Usual adult dose is 2 Inlay-Tabs, q.i.d. In bottles of 50. ℞ only. Remember, to contain the bacteria-prone cold...TAIN.

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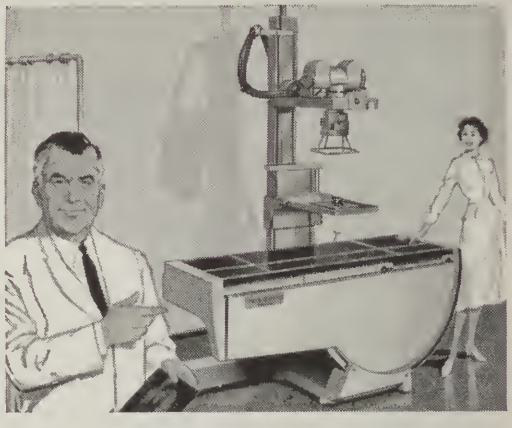
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When anatomical motion threatens to blur radiographs, the 200-ma Patrician can answer with extreme exposure speed, *twice* that of any 100-ma installation. Film images show improved diagnostic readability . . . retakes are fewer. And you'll find the G-E Patrician is like this in everything for radiography and fluoroscopy: built right, priced sensibly, *uncompromising* in assuring you all basic professional advantages. Full-size 81″ table . . . independent tubestand . . . shutter limiting device . . . automatic tube protection . . . counterbalanced fluoroscope, x-ray tube and Bucky . . . full-wave x-ray output.

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NEW **isoclor** acts here to relieve both nasal and chest discomfort

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TABLETS AND SYRUP

relieves both / upper respiratory congestion bronchial congestion

- **effective** because d-isoephedrine combines both nasal and bronchial decongestant actions[1]—together with the histamine blocking action of chlorpheniramine.
- **fast** . . . clears air passages in 10-20 minutes. Relieves stuffiness, swelling, discharge. Prevents excessive post-nasal drip and resulting night cough.
- **safe** . . . Laboratory studies reveal little effect on CNS or pressor stimulation.[2] Minimal daytime drowsiness or interference with sleep.

1. Aviado, D. M. et al: J. Pharmacol. & Exper. Therap. 122: 406-417 (Mar.) 1958. 2. Laboratory Report: Research Div., Chas. C. Haskell & Co., 1959.

TABLETS AND SYRUP for adults and children . . .

COMPOSITION:	Per tablet	Per 5 ml. syrup
Chlorpheniramine maleate.....	4 mg.	2 mg.
d-Isoephedrine HCl.....	25 mg.	12.5 mg.

DOSE: Tablets: Adults: 1 tablet 3 or 4 times daily. Syrup: Children: 3-6 yrs. ½ tsp. t.i.d.; 6-12 yrs. 1 tsp. t.i.d. Adults: 2 tsp. t.i.d.

AVAILABLE: Tablets: Bottles of 100. Syrup: Pint bottles.

ARNAR-STONE
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taken at bedtime

BONADOXIN®

STOPS MORNING SICKNESS IN 94%

OFTEN WITH JUST ONE TABLET DAILY

by treating the symptom—nausea and vomiting—as well as a possible specific cause—pyridoxine deficiency



each tiny Bonadoxin tablet contains:
Meclizine HCl (25 mg.) for antinauseant action
Pyridoxine HCl (50 mg.) for metabolic replacement.

usual dose: One tablet at bedtime; severe cases may require another tablet on arising.

supply: Bottles of 25 and 100 tablets. Bonadoxin also effectively relieves nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, and motion sickness. Also useful in postoperative nausea and vomiting.

Bibliography on request.

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Pain Reliever

Professional confidence in the uniformity, potency and purity of Bayer Aspirin is evidenced by ever increasing recommendation. Bayer Aspirin is the most widely accepted brand of analgesic the world has ever known.

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In over five years

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Effective
for relief of anxiety and tension

Outstandingly Safe

1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
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3. does not produce ataxia, change in appetite or libido
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meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.
Also as MEPROTABS*—400 mg. *unmarked,* coated tablets; and as MEPROSPAN®—400 mg. and 200 mg. *continuous release* capsules.

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...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

NEW analgesic

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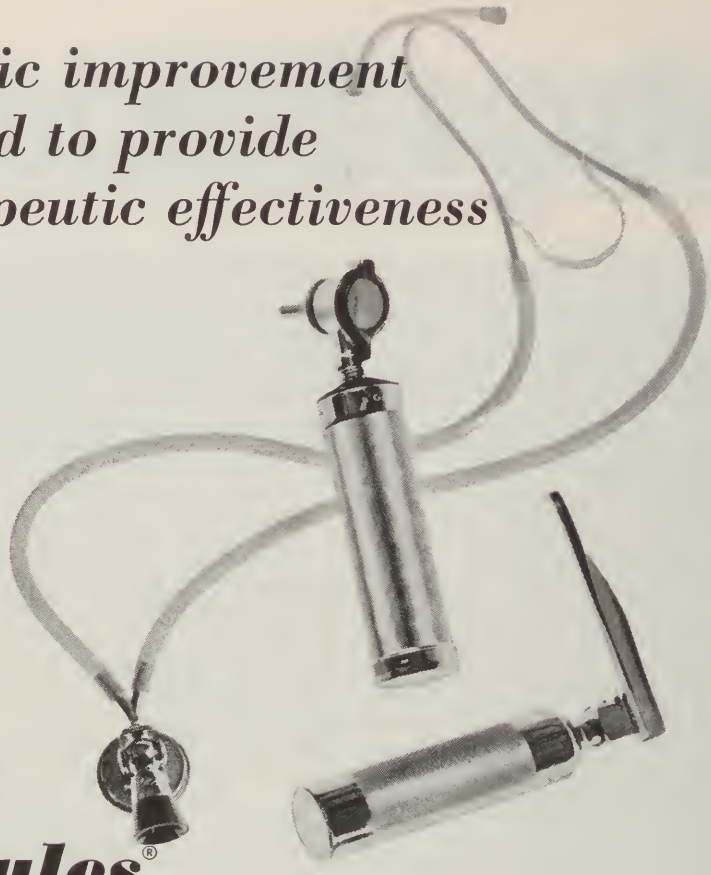
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A Plan For Management Of Rh Negative Mothers And Erythroblastosis Fetalis

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The problem of erythroblastosis fetalis in a community hospital is discussed, with a summary of cases. A program for Rh negative mothers, factors in preventing stillbirth are presented

ERYTHROBLASTOSIS fetalis is a disease of the fetus and newborn caused by blood-group incompatibility between mother and child.[1] This incompatibility may develop when there is an antigen on the fetal red blood cell which is absent from the maternal red blood cell.

Fetal red cells frequently enter the maternal circulation through a break in the integrity of the placental barrier and, once in the maternal circulation, may evoke a specific antibody response if the above situation exists. The maternal antibodies which are formed cross the placenta, enter the fetal circulation, attach themselves to the fetal red cell antigens, and this union results in destruction of the red cell. In the severest forms of the disease the anemia resulting from this red cell hemolysis may be enough to cause intrauterine fetal death.

If the infant is born alive, the severe anemia may cause congestive failure and neonatal death. In addition, the liver of the newborn erythroblastotic infant is confronted with the problem of handling large amounts of protein-bound (indirect) bilirubin from excessive red cell hemolysis. This indirect bilirubin must be converted to bilirubin glucuronide (direct bilirubin) in the liver to be excreted in the urine. A deficiency of enzymes in the liver during the first few days of life results in impairment of this conversion. This enzyme deficiency is likely to be more marked in the premature infant than in the term infant.

When the serum indirect bilirubin concentration in the blood becomes sufficiently elevated, the basal ganglia of the brain may become stained with this pigment and result in the clinical entity of kernicterus. This condition may cause death or athetoid cerebral palsy and deafness.

Althought the A-B-O blood group incompatibilities are more common, the largest number of severe cases of erythroblastosis occurs in infants born to Rh negative mothers. These mothers comprise 12-15 per cent of the average obstetrical practice and since only a limited number of these mothers become sensitized,

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any one physician's experience with this problem may be somewhat limited.

To determine the extent of this problem on the obstetrical service of a community hospital, the experience with Rh negative mothers at the Hazard Memorial Hospital during the period April 1956 through January 1960 was reviewed. A total of 1,063 mothers delivered 1,229 infants of 20 weeks gestation or more with a perinatal mortality of 53 (4.3%). (See Table 1).

TABLE I

	Total	Rh Pos.	Rh Neg.
Deliveries	1213	1047	166
Infants	1229	1062	167
Mothers	1063	917	146
Neonatal Deaths	26	23	3
Stillborns	27	21	6
Perinatal Mortality	53	44	9

Deliveries and perinatal mortality, Hazard Memorial Hospital, April 1956 through January 1960.

There were 146 Rh negative mothers (13.7%) who delivered 167 infants with a perinatal mortality of 9 (5.4%). (See Table II).

Following is a summary of 19 infants who had erythroblastosis:

1. Two stillborn infants
2. One neonatal death
3. Six infants with severe erythroblastosis who received a total of 14 exchange transfusions (One infant received 5 exchange transfusions, 2 infants each received 3 exchange transfusions).
4. Ten infants had positive Coombs tests with or without clinical evidence of mild erythroblastosis. No exchange transfusions were given to this group.

The number of problems encountered indicates the necessity for a plan of management which will result in early recognition of those cases in which difficulty due to erythroblastosis might be anticipated. In addition, this plan should include adequate preparations to care for the newborn infant to prevent the complications of neonatal death or kernicterus.

Management of the Rh Negative Mother

The care of the Rh negative mother should include the usual facets of good prenatal care, i.e. complete history, thorough physical examination, dietary instruction and supplementation and periodic visits for follow-up on maternal health and fetal development.

At the first prenatal visit, every patient should have a complete blood typing and Rh genotyping done. The latter is a designation of the Rh characteristics of each gene inherited from each parent. When the patient is typed as Rh negative, the physician is alerted to the possibility that sensitization may occur or has already developed. One must not be lulled into complacency because a woman has had a

TABLE II

Type of Loss	Gestation Weeks	Weight Kg.	Coombs Antibody Titer	Primary Cause of Perinatal Mortality
1. Stillborn	31	1.80	—	Hydrops fetalis, preeclampsia
2. Stillborn	32	0.34	1:32	Erythroblastosis, preeclampsia, ess. hypertension, intra-uterine fetal death @ 24 weeks. (hypofibrinogenemia, postpartum)
3. Stillborn	35	0.77	1:8	Anencephalic monster
4. Stillborn	37	2.25	Neg.	Placental insufficiency
5. Stillborn	32	1.73	Neg.	Circumvallate placenta with separation, acute vasculitis of cord
6. Stillborn	40	3.47	Neg.	Cause undetermined (no erythroblastosis)
7. Neonatal	37	2.37	1:128	Severe erythroblastosis (expired before exchange could be started)
8. Neonatal	26	0.88	—	Circumvallate placenta, velamentous cord, maternal anemia (6.5 Gm. percent)
9. Neonatal	26	0.70	Neg.	Circumvallate placenta with separation

Perinatal mortality in infants of Rh negative mothers, April 1956 through January 1960.

number of normal babies. Three of our patients delivered eight, nine and 13 normal infants respectively before delivering an infant with evidence of erythroblastosis.

If the patient is Rh negative, one should proceed in an orderly fashion with the following steps:

STEP A. Determine the blood type and Rh genotype of the husband. If the husband is Rh negative, nothing further need be done until the infant is born at which time the cord blood should be examined as in STEP G. If the husband is Rh positive it should be determined from the genotype if he is homozygous (the Rh characteristics of the genes inherited from each parent are alike) or heteozygous (the Rh characteristics of the genes inherited from each parent are different). If the husband is homozygous Rh positive all of his children will inherit the same type gene and all will be Rh positive. If the husband is heterozygous there will be only a 50 per cent chance for the child to inherit the gene with the Rh positive characteristic. (See Table III).[7]

TABLE III

Reaction Anti-D	Reaction Anti-C	Reaction Anti-E	Reaction Anti-c	Likely Genotype	Heterozygous or Homozygous
+	+	+	+	DCe/DcE	Homozygous
+	+	—	+	DCe/dce	Heterozygous
+	+	—	—	DCe/DCe	Homozygous
+	—	+	+	DcE/dce	Heterozygous
+	—	—	+	Dce/dce	Heterozygous

Presumptive determination of father's genotype using various Rh typing sera.

STEP B. When the husband is Rh positive the past obstetrical history must be reviewed with respect to the period of gestation of each pregnancy, development of maternal Rh antibody titers, outcome of the pregnancy, and evidence of fetal or neonatal erythroblastosis.

STEP C. As soon as possible a qualitative Rh antibody screening test should be done on the maternal serum. If this is positive a quantitative Rh antibody titer should be performed. Both of these procedures should utilize Rh positive test cells suspended in saline and albumin and an indirect Coombs test should be done on the test cells which have been exposed to the maternal serum.

STEP D. If the initial Rh antibody titer is negative it should be repeated at 30 and 35 weeks to determine if maternal sensitization has developed. If the initial Rh antibody titer is positive it should be repeated at 25, 30 and 35 weeks. An increasing titer indicates the maternal sensitization is becoming more severe and one may possibly expect the fetal involvement to be greater.

STEP E. Any mother with a history of an erythroblastotic infant or a positive Rh antibody titer should have the benefit of obstetrical consultation. In addition, the case should be discussed with the pediatrician who will be responsible for the care of the newborn infant. Preparations must be made for a possible exchange transfusion. These preparations include the location of several suitable type O Rh negative donors who are easily available and able to donate blood at the time the infant is delivered. These donors may be either male or female and the titer of naturally occurring anti-A or anti-B antibodies in the donor blood should be less than 1:100. In addition, the prospective donor cells should be crossmatched against the maternal serum since the antibodies present in the baby's serum are also present in the maternal serum.

We use a "Worksheet for Rh Negative Mothers" to insure completeness in the prenatal management. It also serves as a convenient summary of pertinent information when attached to the prenatal record. (See Figure I and II).

STEP F. The cord should be clamped as soon as the baby is born to prevent further overloading of the fetal circulation by a "placental transfusion" since the most important cause of early neonatal death in erythroblastosis is congestive heart failure. Since it may be necessary to utilize the cord for an exchange transfusion, it should be left about 6 inches long and kept moist with saline compresses.

STEP G. Cord blood should be collected from every infant born to an Rh negative mother and the following tests performed:

1. Blood type and Rh genotype. It is fre-

FIGURE I (Front of Worksheet)
WORK SHEET
RH NEGATIVE MOTHERS

Name: Blood Type:

Unit #: Genotype:

Age:

Address:

Phone:

Husband: Blood Type:

Unit #: Genotype:

Homozygous:

Past Medical History, Transfusions, Blood Injections:

OBSTETRICAL HISTORY

Year	Gestation Weeks	Antibody Titer	Complications, Type of Delivery	Status of Child	Child's Type & Genotype
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Remarks:

FIGURE II (Back of Worksheet)

PRESENT PREGNANCY

LMP: EDC:

Gestation	Estimated Date	Date Done	Rh Antibody Titer		
			Saline	Albumin	Coombs
(1st Visit)					
25 Weeks					
30 Weeks					
35 Weeks					
Other					

Suitable Donors by 30 Weeks Est. Date _____

Name	Address	Phone	X-Match
1.			
2.			
3.			
4.			
5.			

Pediatrician Notified:

Recommendations:

Baby of this pregnancy:

Type _____ Coombs _____

Hb. _____ Bilirubin _____

quently difficult to type the infant's blood because Rh positive cells which are heavily coated with Rh antibodies may react like Rh negative cells.

2. Direct Coombs test. If this test is negative nothing further need be done. If the test is positive it indicates that antibodies produced by the mother have entered the fetal circulation and united with the Rh antigens on the fetal red cells. A positive Coombs test establishes the diagnosis of erythroblastosis fetalis although the clinical picture may not be evident at birth.

3. Hemoglobin, hematocrit and serum bilirubin should be done when the Coombs test is positive.

Special Problems

Rh negative mothers who develop a positive Rh antibody titer, have had previous pregnancies complicated by stillbirth due to erythroblastosis, or have given birth to severely involved liveborn infants present special problems. As many as one-third of the stillbirths due to erythroblastosis occur prior to seven months gestation.[1] A woman who has had one child stillborn because of erythroblastosis runs a 75 per cent chance that the next fetus will be stillborn.[3] A woman who has had two stillbirths because of erythroblastosis runs a 90 per cent chance of stillbirth with the next pregnancy.[3]

Rh positive infants born to sensitized Rh negative mothers often follow a pattern in the severity of their erythroblastotic involvement, i.e. if one infant is severely involved, the next Rh positive infant is likely to be severely involved.

Planned early termination of pregnancy can salvage some of the fetuses which would otherwise suffer intrauterine death in the last 5 to 7 weeks of pregnancy.[3, 10] It is difficult to set exact rules as to when each of these cases may be terminated with promise of increased fetal salvage. We feel that the following criteria indicate delivery at 37 weeks gestation:

1. Husband is homozygous Rh positive
2. Rh antibody titer is slightly elevated or rising
3. The previous infant has had mild erythroblastosis.

Delivery is indicated at 33 to 35 weeks gestation if the following are true:

1. Husband is homozygous Rh positive
2. Rh antibody titer is 1:64 or more, or rising
3. There is a history of stillbirth, premature birth, or neonatal death due to erythroblastosis.

Patients who do not fulfill all of these criteria must be individually considered with reference to early termination of pregnancy. It has been noted by a number of observers that a cessation of fetal growth or a marked decrease of fetal activity may indicate serious erythroblastosis and early termination of pregnancy should at least be considered. An important evaluation in all cases where early termination of pregnancy is considered is the problem of prematurity to be imposed on the newborn infant.

It should be noted that a possible complication of intrauterine death is the development of maternal hypofibrinogenemia with its resultant hemorrhagic manifestations.[8, 9] This is most likely to occur if the period of gestation is more than 16 - 20 weeks and the dead fetus has been retained in the uterus longer than 5 - 8 weeks. Further discussion of this complication is not within the scope of this presentation.

The indications for method of delivery, induction of labor, analgesia and anesthesia are dictated by the obstetrical evalution of the individual patient. A minimum of analgesia and a type of regional anesthesia should be utilized when possible since these infants may be in extremely poor condition.

Case Report

The management of some of the problems mentioned above is illustrated in the following case report:

Patient was a 24-year-old gravida 4, para 3 who received five pints of blood at the time of a surgical procedure in 1952. Her first infant was delivered at term in 1956 and became jaundiced shortly after birth. The baby received several simple transfusions and developed kernicterus. The second and third pregnancies ended in premature delivery at 32 and 37 weeks respectively. Both babies died within 30 - 60 minutes because of severe erythroblastosis.

The mother was type A, Rh negative (cde/-cde) and the father was type O, Rh positive, homozyous (cDE/cDE). After the third pregnancy the mother's serum showed an Rh antibody titer of 1:128.

During the fourth pregnancy the Rh antibody titer was 1:128 at 31 weeks. After consultation it was decided that the pregnancy should be terminated at about 33 weeks gestation and the patient was admitted to the hospital. She had a severe upper respiratory infection and termination was postponed.

At 35 weeks gestation she re-entered the hospital and stated that the baby had been noticeably less active in the preceding 30 hours. Blood was made available for the infant and labor was induced by amniotomy and intravenous Pitocin® drip. A living female infant weighing 2290 grams (5 lbs. 1 oz.) was delivered spontaneously using pudendal block anesthesia.

The baby was pale and the liver and spleen were palpable below the costal margins. An immediate exchange transfusion was started and the initial venous pressure was 15 cm. The cord blood showed the baby to be type O, Rh positive, Coombs test positive, Hb 7.2 Gm. per cent, total bilirubin 11.9 mg. per cent, direct bilirubin 0.9 mg. per cent. A second and third exchange transfusion was performed at 12 and 27 hours of age when the serum indirect bilirubin approached 20 mg. per cent. The baby was discharged on the eleventh day and has grown and developed normally. At 1 year she weighs 20 pounds, walks alone, and has a vocabulary of 9 words.

Management of Erythroblastosis Fetalis

The pediatrician should not be satisfied to enter the picture after the erythroblastotic infant has been delivered and await the results of laboratory tests on the cord blood before deciding if an exchange transfusion is indicated. Instead the pediatrician should play an active role during the pregnancy, consult with the obstetrician, evaluate the factors previously discussed, help make the decision concerning the time of delivery and be prepared to perform an exchange transfusion if necessary. The pediatrician should be present at any delivery when the probability of an erythroblastotic infant exists.

Again we emphasize that one should not be lulled into complacency by a benign past obstetrical history. The infant of any Rh negative mother should be examined as soon as possible after birth. These infants should be evaluated carefully for degree of maturity since it is known that the premature infant is less capable of handling serum indirect bilirubin than is the mature infant. The color of the infant, especially the presence of pallor, and evidence of edema should be noted.

The absence of clinical icterus at birth should not be interpreted as an encouraging sign since even severely erythroblastotic infants will not become icteric until several hours after birth. This is largely attributed to fetal bilirubin passing through the placenta into the maternal circulation, but there are other poorly understood reasons why the infant is not icteric at birth. The appearance of icterus during the first 24 hours of life is always abnormal and should be investigated.

Many severely erythroblastotic infants will not develop hepatomegaly or splenomegaly until several hours after birth, if at all. The presence of hepatomegaly at birth, however, should alert the examiner to the possibility of congestive failure, especially if accompanied by pulmonary edema.

Criteria Vary

The criteria for planned early delivery which were discussed previously are also sufficient to warrant an exchange transfusion of the infant immediately after delivery, even before laboratory tests on the cord blood are completed. To delay the exchange while awaiting results of the laboratory tests could be disastrous because of the severe anemia and possible congestive failure of the infant. Other than these, the criteria used for an exchange transfusion vary somewhat from one author to another. Regardless of whose criteria are used all available data must be evaluated and each case must be considered individually. Careful clinical judgment, which will be influenced by previous experience, must be exercised.

We have found the indications for an exchange transfusion used by Allen and Diamond to be very valuable.[1] These indications listed below are based on a definite diagnosis of erythroblastosis, i.e. the infant must be Rh positive and have a positive Coombs test:

1. Anemia at birth, with a cord blood hemoglobin of 13 Gm. percent or less
2. Serum bilirubin of cord blood elevated to 7 mg. percent or higher
3. Prematurity

4. A previous baby with kernicterus or severe erythroblastosis fetalis
5. Maternal anti-Rh titer of 1:64 or higher.

When an erythroblastotic infant can be anticipated, as in a planned early delivery, type O Rh negative donor blood can be made available for the exchange transfusion prior to delivery. After the newborn has been typed, either type-specific Rh negative or type O Rh negative blood can be used. Blood incompatibility should always be ruled out by cross-matching the donor cells against the maternal serum. It is extremely important to use fresh donor blood for an exchange transfusion since the hemolysis of old blood liberates potassium into the plasma and this hyperkalemia may cause cardiac arrest, usually with death of the infant.[2]

Technique of Exchange Transfusion

Although many different types of equipment and procedures for performing an exchange transfusion have been recommended, we have found those described by Allen and Diamond to be satisfactory.[1] The procedure should be performed under sterile conditions with an anesthetist present to record the infant's pulse and respirations, suction the mouth and pharynx and administer oxygen if necessary. It is necessary to have a recorder "keep score" of the amounts of blood withdrawn and injected during the exchange, since a confusion of a few syringes of blood may be enough to cause either shock or congestive failure.

It is customary to perform the exchange through the umbilical vein, which is usually easy to cannulate and may be used repeatedly if properly cared for. In one of our infants five exchange transfusions were successfully accomplished through the umbilical vein. The cord must be kept moist with saline dressing between exchanges, and clots in the vein must be carefully aspirated before starting each exchange. It has been our practice to use a No. 5 French polyethylene feeding tube through which a free flow of blood can be obtained. This small caliber tubing minimizes the danger of pushing a clot into the infant's circulation. A 20 ml. syringe produces a more efficient exchange than a 10 ml. syringe, although the latter should be used when performing exchange transfusions on premature infants or infants in congestive failure.

At the start of the exchange transfusion the venous pressure of the infant should be determined by holding the catheter up and measuring the height of the column of blood against a ruler held vertically on the abdomen just above the umbilicus. The normal venous pressure is about 7 cm. of blood. Values above this usually indicate either overt or impending congestive failure, and should be lowered by withdrawing 20-40 ml. of blood before starting the exchange. The venous pressure should also be measured occasionally during the course of the exchange.

If citrated donor blood is used, 1 to 2 ml. of 10 per cent calcium gluconate solution should be injected after each 100 ml. of donor blood, or when the infant seems irritable or restless. The volume of blood customarily used for the exchange is 1 unit (500 to 600 ml.) which exchanges 85 to 90 per cent of the blood of an average-sized newborn. As a general rule 75 ml. of blood per pound of the baby's weight is a safe maximum to use in an exchange transfusion.

Preventing Kernicterus

After the initial exchange, the infant should be given an antibiotic until it is apparent that no further exchanges will be necessary. The value of giving steroids is doubtful although they may possibly decrease the frequency with which exchanges have to be repeated.[6]

If the infant has survived the first several hours of life, the problem then becomes one of preventing kernicterus. It has been shown that this is a rare complication if the serum indirect bilirubin is kept below 20 mg. per cent.[4] It is important to determine the infant's serum bilirubin every 6 to 8 hours using the micro method if possible.[5] The exchange transfusion should be repeated whenever the level of serum indirect bilirubin approaches 20 mg. per cent. At age 48 hours a term infant is usually capable of converting indirect bilirubin to direct bilirubin at a rate sufficient to preclude further exchanges; a premature infant may require a somewhat longer period.

Every erythroblastotic infant should be examined carefully and repeatedly during the first five days for such signs of kernicterus as opisthotonus, a high-pitched cry, poor sucking

reflex or a poor Moro reflex. If no signs of kernicterus have appeared during the first five days one can feel assured that this disease has been prevented.

Summary

1. The pathogenesis of Rh sensitization in the Rh negative mother and the development of erythroblastosis fetalis and its complications have been briefly discussed.
2. During the period April 1956 through January 1960, 146 Rh negative mothers delivered 167 infants at Hazard Memorial Hospital. A summary of the 19 infants who were diagnosed as having erythroblastosis fetalis has been given.
3. The salient features in the management of the Rh negative mother and the erythroblastotic infant are discussed and illustrated by a case report.

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The General Surgical Approach To Renal Calculi*

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The surgeon's success in finding the causative parathyroid adenoma will be enhanced by the adoption of a rigid discipline of anatomic dissection, and a philosophy of indirection

ALTHOUGH HISTORICALLY bone and dental abnormalities have predominated in the past, renal lithiasis is now the most common complication of *hyperparathyroidism*, accounting for perhaps 5% of all ureteral calculi.[1,4]

Hyperparathyroidism at the present time is classified as Primary, Secondary, Pseudo, and lately Pseudo-pseudo. Our interest as general surgeons lies with the first of these categories, primary hyperparathyroidism, which is due in over 95% of the cases to a parathyroid adenoma; very infrequently, to simple hyperplasia; and rarely to carcinoma.

The treatment of primary hyperparathyroidism is essentially surgical, and consists simply in finding and removing a hyperfunctioning adenoma, or in demonstrating and subtotally resecting, hyperplastic parathyroid tissue. The operation, which at times is deceivingly simple, most often proves discouragingly baffling and protracted for the following reasons:

1. The minute size of normal parathyroids.
2. The great variation in "normal" location of parathyroids.
3. The frequency of ectopic location of parathyroids.
4. The ease with which even minute bloody oozing in the surgical field can hide parathyroid tissue.

To overcome these obstacles, much has been written about the anatomical and embryological background for the diverse locations of parathyroid glands and adenomata. In addition, the meticulous operative technique necessary has been carefully detailed by Cope and others.[2, 3, 4] Nevertheless, it still happens that technically proficient, and experienced, surgeons repeatedly fail to find parathyroid adenomas, or to demonstrate and subtotally resect hyperplastic parathyroid glands.

It has been said that the choice of a surgeon for a case of hyperparathyroid disease is not merely to find one who is skilled in thyroid and neck surgery but preferably one who has had twenty to thirty parathyroid resections "under his belt." Practically, in most communities except the great metropolitan centers, this is unfeasible. More often than not, an otherwise experienced surgeon who has had only a nodding acquaintance with parathyroid surgery will be called upon to investigate a case of hyperparathyroidism.

Having in the past watched and assisted skillful surgeons who consistently failed to find adenomas, I am convinced that such failure can often be attributed to two factors not usually mentioned in essays on the subject of parathyroid surgery. These are:

1. *Mental Attitude.* The surgeon should approach the operation convinced that an adenoma or parathyroid hyperplasia is present and that it only remains for him to demonstrate

From the Department of Surgery, University of Louisville School of Medicine, and the Norton Memorial Infirmary. Presented at the Second Annual Post Graduate Medical Seminar, Norton Memorial Infirmary, Louisville, Kentucky, Dec. 17, 1959.

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the condition at the operating table and to correct it surgically.

The surgeon should also be prepared mentally and philosophically to spend willingly upwards of two to three hours in an unhurried painstaking, almost bloodless, demonstration of normal anatomy in the neck, with implicit faith in the success of his endeavor. Doubt, discouragement, and haste are promptly transmuted into careless slipshod techniques which will cause the search to fail.

2. *The Discipline of Anatomical Indirection.* By this I mean the very difficult discipline of forcing oneself to forsake the direct search for an adenoma in favor of the duller, but more exacting, procedure of anatomical demonstration of the existing parathyroid bodies in the patient's neck. This calls for an unhurried, gentle, almost bloodless skeletonizing dissection of the neck from the level of the hyoid bone to the superior mediastinum, beginning on one side, and attempting to demonstrate the superior and inferior parathyroid bodies on that side before passing to the other side for a similar demonstration.

This orderly anatomical demonstration may:

a. Reveal the adenoma sought.
b. Disclose that one parathyroid is missing, indicating an ectopically located adenoma in the neck or mediastinum.
c. Reveal an aberrant vascular pedicle which can be traced to a hidden adenoma.
d. Demonstrate parathyroid hyperplasia in the absence of an adenoma.
e. Disclose a second adenoma, said to be present in 20% of cases.

Technique

With the foregoing cardinal principles firmly fixed in mind as to their primacy, the technique of the operative demonstration I prefer is given below.

A generous low collar incision wider than that used for thyroidectomy is employed, reflecting the platysma with the upper flap. The sternomastoid muscles on either side are freed from the fascial envelope along their anterior margins. The cervical fascia is vertically split in the midline and the strap muscles are divided transversely, without using clamps. Visible veins on the anterior aspect of the muscles are transfixed before division. Bleeders in the muscle substance are individually clamped and tied. The severed muscles are retracted by means of one or two mattress sutures of cotton.

With the entire anterior surface of the thyroid gland exposed, the surgeon studies and palpates its surfaces and contours, looking for any irregularity or asymmetry that might lead to the location of an adenoma. Many advocate direct primary attack on such an asymmetric area of obvious solitary lump, since it may be the adenoma sought and thus may shorten the operation.

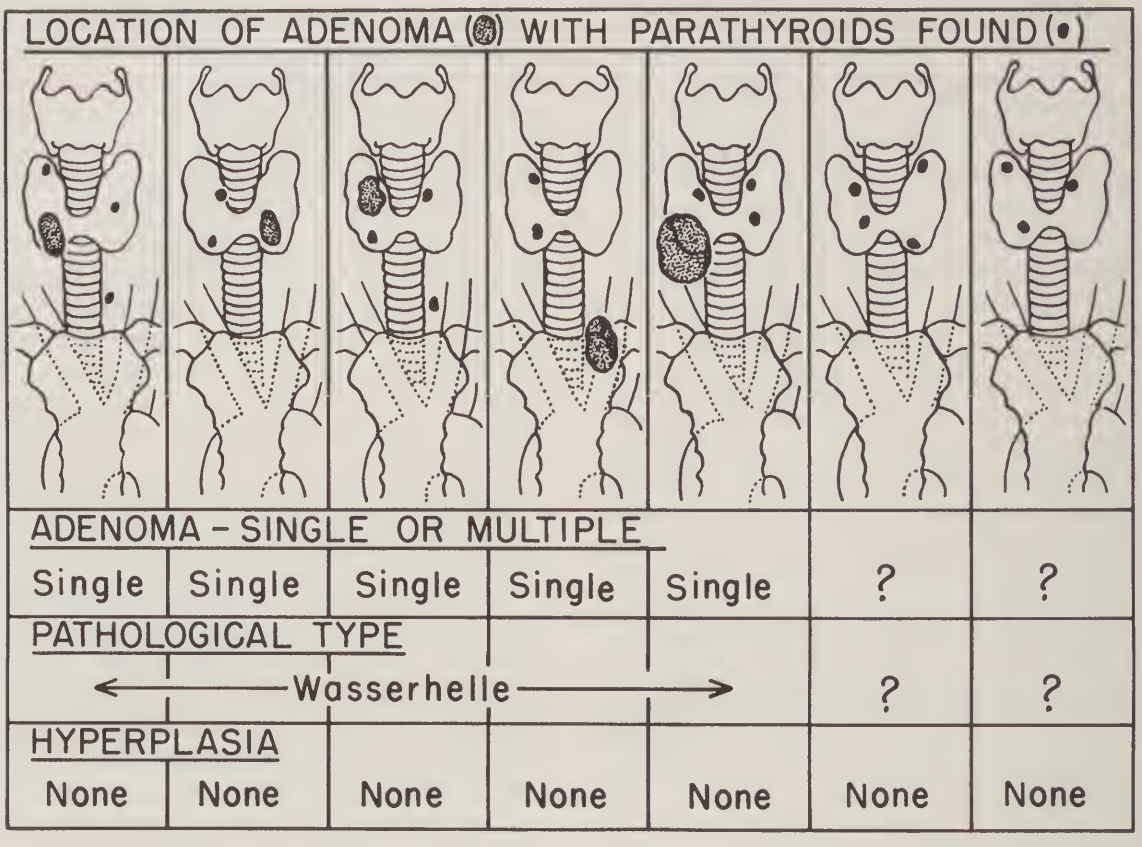
I maintain that a lump or asymmetry is the *last* place to be attacked. It will wait and not disappear and can be found later easily, even if unhappy accidents distort and obscure the operative field. On the contrary, if one approaches it first, and it proves not to be parathyroid tissue, all too often the surgical field is bloodied and compromised and the search for a less obvious, smaller, and more remote mass will be that much more difficult, and the demonstration of hyperplasia will be well nigh impossible.

Skeletonizing Dissection

The skeletonizing dissection begins with the superior pole vessels of one side which are cleared of fat and areolar tissue, then divided between ligatures. The superior pole itself is then mobilized and cleared, and then the lateral veins are also cleared and divided between ligatures. This enables the surgeon to reflect the superior pole and midportion of the gland medially, exposing the posterior surface; a frequent location of superior parathyroid bodies.

At this time the lateral pharyngeal wall and laryngo-pharyngeal cleft, and retropharyngeal plane are visualized and cleared. Usually by this time a parathyroid body is demonstrated. Its appearance and size are noted. In the presence of a hyperfunctioning adenoma, other parathyroid bodies will be atrophic.

Next, the inferior thyroid artery and its several branches are skeletonized and after clearing the main trunk may be ligated in continuity to reduce bleeding. The recurrent nerve is looked for and cleared. It usually will be readily found among the arborizations of the



inferior thyroid artery. The tracheoesophageal groove is cleared and the retroesophageal space is entered and carefully cleared. The inferior thyroid artery may now be divided between ligatures to help in this exploration, so that the entire hemithyroid can be reflected medically and inverted. After one side, usually the right, is cleared and skeletonized, the demonstration is repeated in similar fashion on the left.

After both sides of the neck have been skeletonized, if any parathyroid body is not demonstrated or if an adenoma is not disclosed, the superior mediastinum down to the aortic arch is cleared and the area carefully scrutinized and palpated, through the original incision. Careful search is made for an aberrant vascular pedicle, usually arising from the inferior thyroid artery, that might lead to an ectopic parathyroid or adenoma.

If careful search fails to reveal an adenoma in the neck or superior mediastinum, and if the usual complement of parathyroid bodies has not been demonstrated, the surgeon has the option of either proceeding to a formal mediastinotomy by splitting the sternum, or of closing the neck, checking the diagnosis with further studies, and doing a mediastinal exploration later, if warranted. Because of the morbidity, I, like others, tend to favor the latter choice.[3, 4] Because of the reported occurrence of intrathyroid parathyroid adenomas, I feel that if the patient is past puberty, and if the thyroid gland itself is irregular or nodular, a total or near-total thyroidectomy is permissible if a careful search has failed to demonstrate either an andenoma or the usual complement of parathyroid bodies.

Results

I have been asked to explore seven cases of suspected parathyroid disease in the past six years. Of these, an adenoma was found in five. Table (above) shows approximate location of the adenomata found, and the extent of the successful anatomical demonstration of parathyroid bodies.

All were adenomatas of the "Wasserhelle" type. No cases of multiple adenoma or of hyperplasia occurred in the series. One ectopic adenoma was recovered from the superior mediastinum through the neck incision. In one

case, mediastinal exploration was concurrently done after a negative neck exploration. An adenoma was not found. Subsequently, the patient's blood calcium, phosphorus, and calcium excretion levels returned to normal. All of this patient's many urinary calculi came from one kidney, and it is presumed that primary renal disease, and secondary hyperparathyrodism or pseudohyperparathyroidism existed rather than primary hyperparathyroid disease.

The other patient in whom an exhaustive search in the neck failed to reveal an adenoma, was subjected, rather empirically, to total thyroidectomy at the completion of the search. Although the pathologist did not find an included parathyroid adenoma, the patient's calcium metabolism reverted to normal and his urinary lithiasis ceased permanently, after this procedure. We assume, with some justification, that a parathyroid adenoma must have been removed.

Conclusions

1. Renal lithiasis is the most common complication of hyperparathyroidism, and accounts for 5% of *all* renal calculi.

2. Despite skill and a detailed knowledge of anatomy and embryology, surgeons still fail conspicuously to find parathyroid adenomas or hyperplastic parathyroid glands, the two most important causes of primary hyperparathyroidism.

3. In the opinion of the author, the two major causes for failure of the surgical search are:

   a. An improper mental approach to the operation, characterized by lack of confidence in the diagnosis, haste, and an unwillingness to squander several hours of a busy day in a painstaking ritual.

   b. Failure of the surgeon to adopt a discipline of indirection, actually avoiding or forsaking the search for the finite object in favor of an orderly ritual of anatomical demonstration during which the object sought has the greatest chance of being disclosed.

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Adhesion of Solid Particles to Solid Surfaces

The adhesion of particles found in polluted atmospheres to typical construction materials was studied, as were effects of humidity upon the adhesion. Humidity-conditioned particles were sprinkled on a pre-conditioned solid surface, and the size distribution of the particles adhering was determined. Solid and adhering particles were then subjected to centrifugal force, tending to throw the particles off. Adhering particles were measured after centrifugations applied at successively higher speeds. The particles remaining, as speeds increased, were found to shift regularly toward smaller sizes. Calculations based on the experimental results indicate that winds and vibrations re-entrain little actual particle debris once it becomes attached to various surfaces. The effects of humidty were found to vary with the materials comprising the particles and surfaces.

M. C. Kordecki and C. Orr, Jr., AMA Archives of Environmental Health, July, 1960

The Several Faces Of Multiple Myeloma*

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From corneal calcifications to uremia, from recurrent pneumonias to osteoporosis, multiple myeloma masquerades in many guises as a wily diagnostic challenger to the physician

THE following case reports are notable as examples of three entirely different clinical aspects of a disease which has for years enjoyed "classical" descriptive features. Multiple myelomais is no longer to be thought of in classical terms, but rather as an ever broadening disease complex.

First Case

The first case is a 76-year-old Negro male admitted to Hopkins County Hospital for the fourth time in June 1958. He complained of chills and fever for the preceding four to five days. There was no localizing symptom. His three previous admissions to the hospital were each for pneumonitis, the first being in May 1956. On each of these occasions a rather severe hypochromic anemia had been noted and was considered to be nutritional in origin. The pneumonia each time cleared promptly with antibiotics, but the anemia appeared unaffected by iron and transfusion.

His examination was notable only in that he had a temperature of 106, and a penile abrasion. The laboratory findings included a hypochromic microcytic anemia with a hemoglobin of 7.2 gms. The white count was 15,000, with 20 per cent lymphocytes, of which five were unclassified. The sickle cell trait was not demonstrated. Bence-Jones protein was present in the urine. The total protein was 9.2 gm. %; albumin 3.0 gm.%; globulin 6.2 gm. %. The zinc turbidity was 60 Kunkle units. Serum uric acid was 6.45 mg. %. A blood culture revealed beta hemolytic streptococci. Sedimentation rate, serum calcium, alkaline phosphatase, BUN and febrile agglutinations were normal. However, the anti-streptolysin O titre rose from 50 Todd units to 250 Todd units. Cryoglobulins were not demonstrated in the serum; however, pyroglobulins were present in the serum at 56 degrees C. in 3½ hours. The water dilution screening test for macroglobulins was positive.

Electrophoresis of the urine protein demonstrated a faint spot in the gamma position. There were no definite x-ray changes. The bone marrow showed a prominence of plasma cells and was considered compatible with myeloma. The apparent streptococcal septicemia cleared easily.

The patient had several subsequent admissions, primarily for anemia, and died one year later with rapidly mounting azotemia and hypercalcemia. An autopsy was not obtained.

In summary, this was a case of recurrent pneumonia and anemia, the true nature of which was unrecognized until multiple myeloma was suspected, after which many of the characteristic findings of the disease were demonstrated.

Second Case

The second case is that of a 66-year-old Negro miner, who was admitted to Hopkins County Hospital for the third time in October 1958. His first admission was for an appendectomy four months earlier, at which time routine blood and urine studies gave no hint of the events to follow. The second admission was two weeks before the third, and occasioned by the onset of malaise and generalized lymphadenopathy. At this time, his peripheral blood

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showed a white count of 15,000 with 44 per cent lymphocytes, half of which were described as atypical. A lymph node biopsy and bone marrow study were described by one pathologist as suggesting reticulum hyperplasia or infectious mononucleosis and by a second as suggesting lymphatic leukemia.

On the third admission his physical examination was unchanged. The suggestion was made that the atypical cells in his peripheral blood and marrow might represent plasma cells. Subsequently, his total protein was 10.3, albumin 2.3, globulin 8.0 gms.%. The zinc turbidity was 5.5 Kunkle units. Bence-Jones protein was demonstrated in the urine, which at that point was showing 4 plus albumin. The serum calcium and BUN were normal. X-rays of the bones revealed no characteristic lesions. Having previously been placed on triethylene melamine under the supposition that his disease represented lymphatic leukemia, he was then placed on urethane. He died a few months later in another hospital, the diagnosis having been confirmed there.

In summary, this is a case of an elderly man with lymphadenopathy, leukocytosis and atypical cells in his peripheral blood, marrow and nodes, which were difficult to classify but which ultimately were associated with the characteristic myelomatous protein changes.

Third Case

The third case is that of a 77-year-old white man whose chief complaint was that of pain involving the entire spine, neck and part of his rib cage. He had lost 30 pounds. He had not had recurrent respiratory infections. His original spine x-rays had shown diffuse osteoporosis, and he had been treated with testosterone. He was referred for further evaluation of his osteoporosis in January 1959.

Physical examination was notable only for tenderness over the vertebrae and the right rib cage. The CBC was normal. The total protein was 8 gm.%, albumin 2.8 and globulin 5.2 gms.%. The urine contained 4 plus albumin and Bence-Jones protein. The zinc turbidity was 35.2 Kunkle units. The blood urea nitrogen and calcium were normal. Bone marrow showed 15 per cent plasma cells. X-ray of the skull showed scattered radiolucent areas compatible with the osteolytic lesions of multiple myeloma. Reappraisal of the spine film showed no characteristic lesions of multiple myeloma, with the exception of the severe diffuse osteoporosis and compression fractures. (Fig. 1) During his hospitalization he developed an acute pneumonitis on the right, which responded readily to penicillin. He was discharged on small doses of urethane and has done quite well to date, his bone pains having disappeared.



Figure 1—X-ray film of the spine showed severe diffuse osteoporosis and compression fractures.

In summary, this is an elderly man with osteoporosis later diagnosed as multiple myeloma.

Discussion

The diverse presenting pictures of these three rather typical instances of multiple myeloma are intriguing. In the discussion that follows, the pathological physiology of this disease will be reviewed, with emphasis on the broad ramifications and manifold possibilities of its clinical expression. When one views multiple myeloma in its broadest sense, it becomes, both clinically and pathologically, a disease spectrum. Figure 2 is an expression of this and is a modification of the concepts of Osserman.[1]

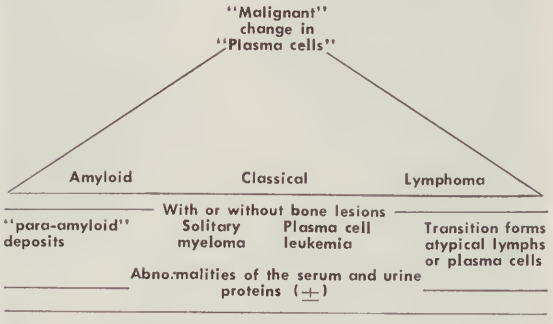
There is evidence to suggest that myeloma is a generalized disease of the hematopoietic system,[2] although it is tempting to think of

the solitary myeloma as autochthonous growth.[3] Nonetheless, many consider a malignant change in the plasma cell to be the fundamental abnormality in this condition. This will be used as a reference point.

Pathologically, multiple myeloma varies from

FIGURE 2

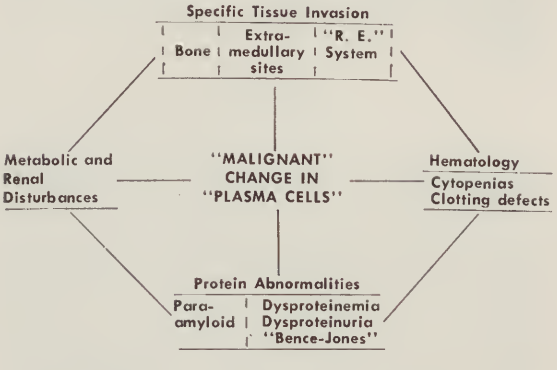
THE PATHOLOGICAL "SPECTRUM" OF MULTIPLE MYELOMA



the presence of lymphocytic forms[4] and atypical plasma cells as illustrated by the second case, through the more classic plasma cell leukemia and the solitary myeloma, to the myeloma associated with amyloid deposits. Actually, amyloid may be present at any point along the spectrum. The classic bone changes may or may not be present, and, if they are, may vary widely. The same is true of the protein abnormalities, although when these are present, they usually take rather characteristic forms.[5,6]

FIGURE 3

THE PATHOLOGICAL PHYSIOLOGY OF MULTIPLE MYELOMA



The high points of the pathological physiology of multiple myeloma are illustrated in (Fig. 3). Here, again, we have the malignant plasma cell as the fundamental abnormality. Associated with this and probably produced by it are protein phenomena, dysproteinemia, dysproteinuria and para-amyloid. The latter has been shown to share some staining characteristics with proteins of myeloma[7] and has been considered by some to represent a variant thereof.[1]

The malignant plasma cell arises in or encroaches upon specific tissues, classified broadly as bone, the extra medullary sites and the reticuloendothelial sites. This invasion influences the hematological manifestations of the disease by the production of cytopenias and clotting defects. These are also influenced by the abnormal proteins. The proteins contribute to renal failure and metabolic abnormalities which are further influenced by the hypercalcemia resulting from bone destruction.

Protein Disturbances

Turning first to the protein disturbances (Fig. 4), we find that the elevated serum

FIGURE 4

The Protein Abnormalities Associated with Multiple Myeloma

Elevated serum globulin. Characteristic electrophoretic patterns.

- Cryoglobulinemia
  Raynaud phenomenon, purpura on cold exposure.
- Macroglobulinemia
  Weakness, lymphadenopathy, bleeding tendency.
- Purpura Hyperglobulinemica
  Dependent purpura
- Pyroglobulinemia
  Heat coagulable globulins found in performance of S. T. S.
- "Bence-Jones" proteinuria
  "myeloma kidney"
- Deficiency of normal Immune globulin
  Repeated infections

globulin and characteristic Beta, Gamma or "M" spikes in electrophoretic patterns are well established diagnostic criteria.[5,6] Associated with these abnormalities are several newly described clinical syndromes whose own peculiar characteristics may represent the presenting symptom in many cases of multiple myeloma.

The first of these is the syndrome of cryoglobulinemia. Cryoglobulins are a group of cold precipitable proteins which have been described primarily in association with myeloma,[8] but cases of so-called essential cryoglobulinemia have appeared.[9,10,11] There is gathering feeling amongst most authorities that these "essential" cases of dysproteinemia may yet prove to be myelomatous in nature if observed for a suf-

ficient period. These cases are characterized by Raynaud's phenomenon, purpura and mottling of the skin upon exposure to cold, a bleeding tendency and marked retinal vascular congestion. A few cases have been associated with Sjogren's syndrome.

The so-called physical allergy to cold should suggest cryoglobulinemia. Direct capillary damage may occur on cooling and reheating; and pulmonary,[12] visceral and cerebral vascular disease have been associated with this condition.

Cryoglobulinemia is not to be confused with the next condition, macroglobulinemia, a condition first described by Waldenstrom. This condition is included because of recent reports associating macroglobulins with multiple myeloma[13,14] and because of the conviction held by some authorities[15,16] that this condtion is a variant of the disease and belongs in the overall spectrum which we are considering. The syndrome of macroglobulinemia consists of weakness, lymphadenopathy, a tendency to nasal, ocular and intracranial hemorrhages, a protracted course occurring primarily in elderly men and associated with a proliferation of small lymphocytic cells.[17] Retinal engorgement has been emphasized in this condition also[18]

Screening Tests

A macroglobulin is a protein with a Svedburg ultracentrifuge constant of 15-20 units and its ultimate detection depends upon this technique.[15] However, screening procedures have been developed in the form of antimacroglobulin precipitation tests, an immunologic procedure, and the relatively unreliable water dilution test; in which the serum is screened for the presence of euglobulins. Macroglobulins may behave like cryoglobulins but, conversely, not all cryoglobulins are macroglobulins.

Another condition described by Waldenstrom is purpura hyperglobulinemica.[19] Case reports of this condition have also described its termination as multiple myeloma.[20] These are characterized by simple dependent purpura which may be confused with the benign dermatological purpuras of Schamberg and Majocchi, and with allergic and thrombocytopenia types.

The apparent converse of these hyperglobulinemia syndromes is the situation illustrated by the first case, in which there is an absence or a markedly decreased amount of normal immune globulin leading to recurrent infections, most commonly pneumococcal pneumonia.[21,22] Various theories have been advanced for this condition, perhaps the most attractive of which is that the abnormal globulins described above compete for the available amino acids in their synthesis and so inhibit the formation of normal immune globulin. Repeated episodes of pneumonia should call for a serum protein determination. The reported association of cryptococcosis with myeloma and other reticulo endothelial diseases may be due to a related immunologic mechanism.[23]

Pyroglobulinemia

Next we come to the recently coined term, pyroglobulinemia,[24] which refers to the heat coagulable protein found in the serum which is thought to be similar in this respect to the Bence-Jones protein found in the urine. The significance of this observation is that multiple myeloma may be suspected first in the laboratory during the performance of a routine serological test for syphilis as the technician attempts to deactivate the complement.[25] Any turbidity occurring in the serum as it is incubated at 56°C. may indicate pyroglobulinemia and the test for Bence-Jones proteinuria should follow.

Bence-Jones proteinuria has long been considered a pathognomonic sign of multiple myeloma. It should be emphasized at this point that these are not the same proteins as are observed elevated in the blood, but are distict biochemically, electrophoretically and antigenically. In addition, each patient has his own biochemically unique Bence-Jones proteins. Isotope studies have shown that their formation and excretion is much more rapid than the serum globulin.[1] The main pathological significance of Bence-Jones proteinuria is that of its association with the so-called myeloma kidney characterized by proteinaceous casts in the tubules with surrounding giant cell reaction and subsequent renal failure.

Amyloidosis (diagrammed in Fig. 5) is related to the protein abnormalities of multiple myeloma. The amyloidosis peculiar to multiple myeloma has been designated para-amyloid because of its inconsistent biochemical and staining characteristics.[1] Initially it involves the

small blood vessels, then spreads through connective tissue stroma. The symptoms, therefore, are those of malfunction of the organ involved. The distribution of this amyloidosis is essentially that of primary amyloidosis as opposed to the secondary type associated with chronic suppuration.

FIGURE 5

The Amyloidosis of Multiple Myeloma

"Para-amyloid"	A designation because of inconsistent biochemical and staining characteristics.
Pathology	Initial involvement is around small blood vessels then through connective tissue stroma.
Clinical Symptoms	Primarily related to local organ involvement.
Distribution	Essentially that of "primary" amyloidosis. Larynx Hoarseness Tongue Macroglossia Skin, Bone, Joints, Tendons, Smooth & Striated Muscle Heart Idiopathic heart failure Adrenal Addison's Disease without tuberculosis Kidney Nephrotic syndrome Nervous System Peripheral Nerves Polyneuropathy Spinal cord Paraplegia Liver

The serum protein studies were performed by Mr. Hugh Earl.

The signs and symptoms of amyloidosis may precede those of the original myeloma.[26] The organs primary involved are the larynx, which may present an unexplained hoarseness; the tongue with the so-called macroglossia; the skin; joints; bones; tendons; smooth and striated muscles. At this point, it should be mentioned that multiple myeloma has been mistaken for rheumatoid arthritis.[27,28] Some cases have even had the typical fusiform swelling of the fingers, joint effusions and rheumatoid nodules and have been reported with or without amyloid deposits.

Involvement of the smooth muscles of the intestines may cause a sprue-like malabsorption syndrome. The heart is frequently involved, and this diagnosis must be considered in cases of idiopathic cardiac failure.[29,30] The adrenal is rarely involved, but Addison's disease not associated with specific infections may occur.[31] Unexplained polyneuropathy due to peripheral nerve encroachment by amyloid may appear. An intriguing example of this is the carpal-tunnel syndrome or median nerve neuritis as it traverses the carpal tunnel of the wrist.[33] The spinal cord may be compressed by amyloid deposits, resulting in a paraplegia. The liver and other reticuloendothelial organs are more commonly involved by secondary amyloidosis.

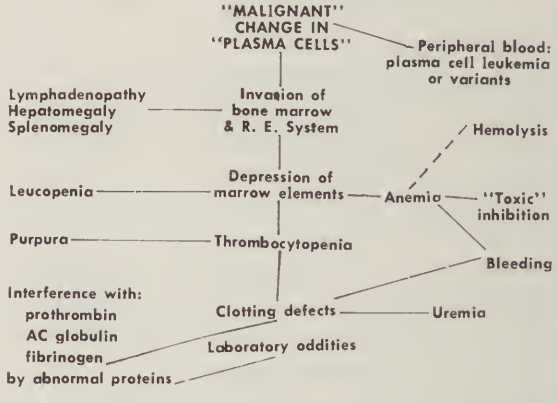
Hematological Changes

The hematological changes of multiple myeloma stem from the malignant change in the plasma cells, with subsequent encroachment on the bone marrow and reticuloendothelial system. (Fig. 6) This leads to the physical signs of lymphadenopathy, hepatomegaly, and splenomegaly, to the depression of the bone marrow elements, and to leukemia, thrombocytopenia or anemia. Add multiple myeloma to the list of differential diagnoses in cases of pancytopenia. However, a normal marrow or failure to find plasma cells does not rule out the disease.

In these cases presenting as an aplastic type of anemia,[34] bone marrow aspiration should be made at multiple sites. Thrombocytopenia is still another cause for purpura in this disease and may represent the primary factor in the clotting defects observed. Other factors influencing the bleeding tendency are those of specific interference by the abnormal proteins with fibrinogen conversion, their demonstrated

FIGURE 6

THE HEMATOLOGICAL CHANGES OF MULTIPLE MYELOMA



coprecipitation with prothrombin and accelerator globulin,[35] and direct capillary damage. The unknown effects of uremia also contribute to clotting defects in this disease.

The anemia of multiple myeloma is most often ascribed to depression of the marrow elements but may also be influenced by the bleeding tendency, hemolysis, and the ill-defined toxic inhibition produced by the malignant cells. As in our second case, the presenting

phenomenon may be invasion of the blood stream by plasma cells or more confusing lymphocytic forms.

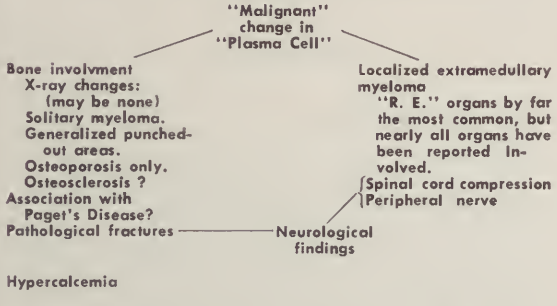
Routine hematology may reveal that the patient's blood behaves in a peculiar manner. Rouleau formation should always suggest the presence of an elevated serum globulin and the tendency of the blood to clot or to gel on cooling suggests the presence of cryoglobulinemia. A greasy serum and bluish background with Wright's stain are suggestive of abnormal proteins. Pyroglobulinemia, as mentioned before, may be first picked up in the course of a routine serology.

Effects of Tissue Invasion

We now come to a review of the effects of the invasion of other specific tissues by the malignant plasma cell. (Fig. 7) Bone involvement is common, and many cases of multiple myeloma have presented in this fashion. It should be stated at the outset of the description

FIGURE 7

THE RESULTS OF SPECIFIC TISSUE INVASION BY MULTIPLE MYELOMA



of x-ray changes that there may be none,[36] in spite of the fact that the marrow may be found involved at autopsy. The solitary myeloma of bone may present as a localized punched-out or rarefied area in any part of the skeleton and may be confused with bony cysts, giant cell tumors, chondromas and sarcomas.

Solitary myelomas are often comprised of the relatively well-differentiated plasma cell and are associated with relatively long duration of disease, but in most cases ultimately culminate in generalized myelomatosis. The generalized punched-out areas of bone are the most common radiological picture and need no further comment. Those cases presenting as diffuse osteoporosis, as did our third case, may present difficulty until the diagnosis is suspected. Osteoporosis in a male should be viewed with the utmost suspicion. Osteosclerosis is included with a question mark because of a single report[37] of multiple myeloma associated with this radiological abnormality.

The association of myeloma and Paget's disease[38] has been reported with sufficient frequency to justify an awareness of this combination. Bone involvement may lead to pathological fractures and, in turn, to neurological findings, which I will discuss in more detail below. Bone involvement by any malignant process, and particularly myeloma, leads to hypercalcemia, an electrolyte disturbance of particular importance for its nephrotoxic qualities.

Extramedullory Myelomas

Turning to localized extramedullary myelomas, we find there is little to guide us in our suspicions. The reticuloendothelial organs, liver, spleen, lymph nodes, lung, upper air passages, and kidney are by far the most common sites of myelomatous invasion, but nearly all organs have been reported involved.[2] Plasmacytomata of the G.I. tract are not distinctive radiologically and may present as abdominal pain and bleeding.[39] The head of the pancreas has been reported as a plasmacytoma site and is an example of the many surprising locations one may encounter.[40]

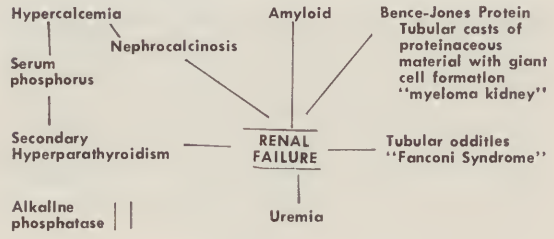
Spinal cord compression by myelomatous invasion of the spinal canal is not an infrequent cause of neurological findings as the presenting feature of myeloma. In the case records of the Massachusetts General Hospital, a case is reported which simulated a ruptured intervertebral disc.[40] Rapidly developing signs of cord compression in a known case of lymphoma, myeloma or any other type of metastatic malignancy constitute a medical emergency for which much can be done to preserve cord function if action is taken in time. Extra-medullary myeloma may also involve peripheral nerves and may present in this fashion, as may its associated amyloidosis. Probably more important is the polyneuritis reported in myeloma in which there is not direct invasion or compression and for which a metabolic mechanism is postulated.[42]

Renal Changes

The renal and metabolic changes in myeloma probably represent one of the areas in which differential diagnosis is often the most difficult. (Fig. 8) Mycloma may involve the kidney in three important ways; the first of these, thought to be associated with the presence of Bence-Jones proteins, is characterized by tubular casts, surrounding giant cell formation, and renal failure.[43] This situation should always be suspected in a rapidly developing renal failure not associated with hypertension. Acute renal failure following intravenous urography has been reported in cases in which this condition was present and unrecognized, indicating caution in cases of unexplained albuminuria.[44,45]

FIGURE 8

RENAL AND METABOLIC CHANGES IN MULTIPLE MYELOMA



Secondly, multiple myeloma may occasionally cause deposits of amyloid about the glomerular tufts and appear clinically as the nephrotic syndrome. Thirdly, the concept of hypercalcemia, nephrocalcinosis, and renal failure is important in association with myeloma.

Hypercalcemia

Hypercalcemia represents, in many instances, a reversible cause of renal failure. One of these reversible causes is hyperparathyroidism, which may, at times, be absolutely indistinguishable from the secondary hyperparathyroidism associated with multiple myeloma, hypercalcemia and renal failure. Even cases originally thought to be parathyroid adenomas pathologically have eventually proved to be multiple myeloma.[46, 47] The protein, bone, and hematological changes are not always characteristic. Alkaline phosphatase, which is usually normal in multiple myeloma, may be a clue.[48]

Careful differential diagnosis is essential in all cases of secondary hyperparathyroidism. In this connection, it should be noted that manifestations of hypercalcemia occuring in the eye; that is, band keratopathy and conjunctival calcifications, have been found in cases of multiple myeloma. Hypercalcemia may underlie the cases of multiple myeloma presenting as a renal calculus.

The renal failure associated with multiple myelomahas been observed to be associated with tubular oddities of which the adult Fanconi syndrome is one.[49] These cases present with renal glycosuria, amino aciduria, albuminuria, alkaline urine with mild systemic acidosis, and other electrolyte changes. The cardinal manifestations of uremia may be the first clue to the underlying disease.

Summary

Three typical cases of multiple myeloma are presented. The presenting feature of each case had caused some previous difficulty in diagnosis and was entirely distinct, one from the other. The pathological physiology of the disease is summarized with emphasis on presenting manifestations which may confound the unwary but reward the vigilant.

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Urine Electrophoresis and Multiple Myeloma

The results of simultaneous electrophoresis of serum and urine in 37 myelomatous patients were evaluated and correlated with necropsy findings when available. Twenty-eight patients had a characteristic paraprotein peak in the serum, 6 also had Bence Jones proteins in the urine. Nine patients did not have a paraprotein peak in the electrophoretic pattern of the serum; all excreted Bence Jones proteins in the urine. At autopsy characteristic hard protein casts of the myelomatous kidney were found only in the renal tubules of those patients who had excreted Bence Jones proteins during life. The urine of 3 patients of the 1st group contained all of the major serum protein fractions in the urine. At necropsy 1 proved to have amyloidosis with extensive glomerular involvement. Twenty to 25% of all myeloma patients do not have characteristic paraprotein peaks in the serum and would escape early diagnosis by serum electrophoresis alone. Since this very group of patients has Bence Jones proteinuria in nearly every instance, electrophoresis of serum and urine will afford a correct and early diagnosis. Appearance of all major serum fractions in the urine signifies amyloidosis with involvement of the renal glomerili.

—H. H. Zinneman, J. Olenchur and D. F. Gleason in Archives of Internal Medicine (Aug.) 1960

Hydatidiform Mole, Chorioadenoma Destruens

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Literature on this complicated form of pregnancy is reviewed, and a summary of diagnosis and management is presented. Acceptance of name, "Chorionepitheliosis" is recommended

THIS rare and complicated form of pregnancy occurs any time during the female reproductive life span. The youngest case known is that of a 12-year-old girl, reported by M. L. Bobrow-S. Friedman[1] and the oldest one, 55 years old, was reported by Eastman[2].

According to different authors, the frequency of hydatid mole in pregnancy varies from 1/2500 (Novak)[3] to 1/126 (Acosta-Sison).[4] Before attempting to establish any linkage between races and molar pregnancy, the careful consideration and evaluation of M. Coppleson's[5] 1/850 incidence rate in Sydney, will be of great value.

Our present day knowledge owes much to Marchand's[6] recognition in 1895, that the hydatidiform mole is chorionic in origin and the chorion epithelioma is its malignant form. The chorionic origin of hydatidiform mole was mentioned in 1812 by a French midwife, Marie Anne Victoire Boivin, in her "Memorial de l'art accouchements"[7] with these words, "These vesicles are the product of a degenerate conception . . . The result of a particular disease of the chorion or the afterbirth."

Ewing's[8] 1910 division of chorion epithelioma into: (1) chorioadenoma destruens; (2) syncytial endometritis; and (3) choriocarcinoma was accepted until the proposal of the term "Chorionepitheliosis" by Schopper and Pliess[9] in 1949. This terminology has been adopted by some authors.[10, 11] The latest trend in pathological obstetrics began with the adoption of this term, which led to various classifications as shown here:

Classification of Chorionepitheliosis by Huber, Hormann, 1952:

Benign Chorionepitheliosis interna: (1) Cell proliferation in the uterine wall (2) Destructive hydatid mole.

Chorionepitheliosis externa: (1) Cell proliferation outside of the uterus; (2) Metastasizing hydatid mole.

Malignant Chorionepithelioma malignum: (Intra-extra genital autonomous cell proliferation)

Benign hydatidiform mole is characterized by proliferation of the covering trophoblast of the chorionic villi (syncytium and Langhans cells) and edema of the core of the villi. There is no tendency to destructive invasion of uterine layers other than its normal invasive potential, which at times appears as trophoblastic metastasis to lung and to vessels.[12] This myometrial infiltration through the decidua, associated with marked inflammatory reaction, often may be seen following any delivery, abortion or expulsion of benign hydatidiform mole, and is simply syncytial endometritis which is often diagnosed as malignant mole or chorionepithelioma.[3]

Chorioadenoma destruens, (penetrating mole, malignant mole, invasive mole) is characterized clinically by its local invasiveness with rarely distant metastasis and pathologically by its abnormal penetrativeness and abnormal degrees of trophoblastic proliferation.

The incidence of malignant change of benign

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hydatidiform mole is about 2%[13] and about 10% of them become abnormally invasive.[14]

Diagnosis

The early diagnosis of molar pregnancy is made difficult by a lack of specific symptoms. Rapid, early enlargement of the uterus, early eclampsia and palpable lutein cysts are most helpful signs.[14, 15] The presumptive evidences and probable signs of pregnancy are not followed by the absolute signs of pregnancy.

X-ray and the determination of the serum chorionic gonadotropin level are helpful in diagnosis and follow-up. The value of X-ray in the detection of the fetal skeleton during the first 12-16 weeks of amenorrhea is practically zero. Any aberration from the normal pattern in the levels of chorionic gonadotropin is a warning sign. In normal pregnancy, serum chorionic gonadotropin reaches its highest level with 600,000 I.U. per liter at the 60th day of gestation.[16, 17]

The level at the 85th day of gestation is about 50,000 I.U.per liter. This drops to 2,000 I.U. around the 100th day. Since the passage of most hydatidiform mole occurs around the 120th day, the diagnostic value of abnormally elevated levels is obvious.

A positive pregnancy test on spinal fluid has no diagnostic value.[18]

Treatment and Long-term Follow-up

Once the diagnosis of hydatidiform mole is established, the uterus should be evacuated by dilatation and curettage or hysterotomy, depending on the size of the uterus. Since the spontaneous expulsion of the hydatifiform mole does not necessarily imply complete evacuation of the uterine cavity curettage should follow expulsion. In 7-10 days curettage should be repeated.

Medical induction of labor, using Pitocin® drip, may be tried before surgical intervention, especially in selected cases. The follow-up treatment of medically induced labor in molar pregnancy must follow the same routine advised for spontaneous expulsion. If hysterotomy is the treatment of choice, logically it should have the advantage of allowing inspection of the degree of penetration of the myometrium by molar degeneration.[19] Practically, however, this is of doubtful value as shown by Douglas' series, in which two out of eight cases needed hysterectomy within 2 months for chorioadenoma destruens.[14]

Since the prognostication of malignant degeneration is made by repeated chorionic gonadotropin titrations, histologic examinations of the molar tissue or chest X-ray, I emphasize the importance of following postmolar cases by routine investigations. The necessity for doing this is attested by reports of perforation of the uterus long after hysterotomy or after the passage of the mole or the appearance of choriocarcinoma.[20, 21]

Chest X-ray and the quantitative pregnancy test should be routine follow-up procedure. The qualitative pregnancy test should be done at monthly intervals for 6 months, then every other month for the next six months. Any positive test is an indication for weekly quantitative determinations for the detection of a possible rising level which, if no new pregnancy is present, is the sign of an invasive mole or chorionepithelioma.

Monthly chest X-rays should be done for the first three months, then quarterly for one year. Any pulmonary symptoms or a rising titer is indication for further chest X-rays. The indications for a third dilatation and curettage may be summarized as a persistently positive pregnancy test associated with subinvolution and persistent bleeding. After the fourth dilatation and curettage, hysterectomy is the treatment of choice.

Summary

(1) The literature on the subject is reviewed. A summary concerning diagnosis, management and follow-up is presented.

(2) The general acceptance of the name "Chorionepitheliosis" is recommended as a clarification of a presently confusing terminology.

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Ruptured Uterus Following Breech Extraction

History and Physical Findings

PATIENT Protocol #30389—B. B., a 21-year-old Negro gravida 5 para 5, with six living children, was first seen in the out-patient obstetric clinic on January 19, 1960. At that time, her expected date of confinement was calculated from the menstrual history to be April 28, 1960. The prenatal course was uneventful, and the patient was admitted to the hospital on May 11, 1960, with the history of recent rupture of the membranes.

On admission, examination showed the cervix to be 7 cm. dilated, and 2 fetal feet were felt in the vagina. The patient was immediately removed to the delivery room and her progress observed. A pudendal block was induced and a mesolateral episiotomy performed while an anesthetist stood by. The baby was allowed to deliver spontaneously to the umbilicus, following which the shoulders were extracted without difficulty.

At this point in the extraction, the head was still high and an attempt at performance of the Mauriceau-Smellie-Veit maneuver met with failure. The operator was able to palpate a rim of cervix, but the hand could easily be inserted between the cervix and the head. At this point, general anesthesia was induced and the Mauriceau-Smellie-Veit maneuver was again attempted, but once more it was unsuccessful. The Piper forceps were then applied to the head, which still lay at a high station. A small rim of cervix could still be felt. The head was then easily delivered with slow forceps traction.

Following the third stage, moderate hemorrhage was noticed. Inspection of the cervix disclosed a laceration on the right side up to the level of the vaginal reflection. The edges were clamped and then sutured as high as possible. Meanwhile, blood had been started parenterally. Bleeding appeared to be controlled for about 15 minutes, but then recurred. The fundus was felt to be firm at this time, but the area close to the right side of the lower uterine segment was soft, and the internal os was tightly closed.

The patient was immediately removed to the operating room and emergency laparotomy was performed. The lower uterine segment was found to be lacerated from the area of the vaginal mucosa to a point some 2 cm. above the level of the uterine artery on the right side. A total hysterectomy was performed and this was successfully carried out without deterioration in the patient's general condition. She left the operating room in good condition.

Several hours later, because of constant vaginal oozing she was again taken to the operating room and the vagina was inspected under anesthesia. A defect measuring 4 by 2 cm. high on the right side of the vagina and extending to the vaginal cuff was encountered. Several figures of eight sutures were applied, and bleeding was then completely controlled.

Post-operatively, after seven pints of blood the hemoglobin level was 6.2 grams. Further transfusions were administered, and the patient made steady progress. An intravenous pyelogram was normal. The patient's subsequent recovery was uneventful, and she left the hospital in good condition on the eleventh post-operative day.

Discussion

*Douglas M. Haynes, M.D.**

Rupture of the uterus is one of the most serious of all mechanical complications of obstetrics, and its proper management is a diagnostic and technical challenge to all obstetricians. The incidence is variously reported, and is highest in hospitals having a large pro-

portion of unregistered patients. Ordinarily, the incidence is of the order of 1:2000.

Uterine ruptures are ordinarily classified as complete or incomplete. A complete rupture is one which extends through the peritoneal covering of the uterus and causes bleeding into the free peritoneal cavity, while incomplete rupture occurs between the leaves of the broad ligaments. The immediate cause of the rupture may be operative trauma, as in the case reported, or the rupture may occur spontaneously in either an intact uterus or a uterus with a scar of a previous cesarean section.

In the case reported, it seems likely that the rupture was a result of laceration of the lower uterine segments by means of the Piper forceps in a difficult extraction of the aftercoming head during breech delivery. This is a relatively uncommon antecedent circumstance for uterine rupture; traumatic rupture of the lower segment is more likely to follow attempts at internal version and extraction, and for this reason this operation has fallen into disuse in well-conducted obstetric practice. In the present case, there seemed to be no reason to suspect that the infant could not be delivered vaginally by the breech mechanism, and the difficulty with the extraction of the aftercoming head could not reliably have been predicted in advance.

The location of this patient's incomplete rupture in the lower uterine segment was such that external hemorrhage signalized the emergency. This clinical finding may not always be the presenting evidence of uterine rupture, as the bleeding may be partially or entirely concealed. Broad ligament hematomas may develop to a considerable size before the clinical findings of shock make their appearance. Complete spontaneous rupture of the uterus will be followed immediately by rapid pulse, hypotension, pallor, clamminess and restlessness, and when the bleeding is entirely intraperitoneal there may be no external evidence of hemorrhage. In such cases, the diagnosis is readily made and immediate laparotomy is indicated on obvious clinical grounds. In other cases, the rupture may be silent, the torn area being compressed by the presenting part, so that signs of shock do not appear until after the delivery.

Once the diagnosis has been made, prompt surgical treatment is mandatory. If a surgical laceration has extended into the lower uterine segment sufficiently to produce a broad ligament hematoma, it is probably futile to attempt repair from below. Valuable time may be lost if such attempts are made, and immediate laparotomy is the first essential of the treatment. The subsequent management depends on the clinical findings at laparotomy. With dissection of the tissues between the leaves of the broad ligament, it is usually impossible to find a bleeding point which can be repaired, and it becomes necessary to perform total hysterectomy.

If the patient is in poor condition, it may occasionally be justifiable to do sub-total hysterectomy provided that this clearly stops the hemorrhage. This is one of the few justifiable indications for the sub-total operation. Occasionally an incomplete rupture through a previous cesarean scar may be found at repeat cesarean section, and in this case hysterectomy is not necessary as many wounds of this type can be repaired. The election of this operation will partly depend on the patient's desire for future childbearing.

The case presented illustrates the necessity for the obstetrician to be prepared to perform extensive abdominal surgery under emergency conditions when the frightening accident of uterine rupture occurs. Delay or vacillation is fatal in this complication.

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SPECIAL ARTICLES

The Presidential Election Of 1960*

IRVIN ABELL, JR., M.D.
1959-1960 KSMA President
Louisville, Ky.

ON November 8, 1960, this country will elect its 35th President. Both candidates are young men—one 43 years and one 47 years of age—with common personal traits which are strikingly numerous. Both Mr. Nixon and Mr. Kennedy are practical professional politicians who have devoted their postwar careers to grass-root politics. Both possess an instinctive feeling for political maneuvering and are quick to seize and exploit every opening for all that it may be worth.

Mr. Nixon and Mr. Kennedy appraise national and international issues with a cool, reserved detachment. They remain calm and unrattled under pressure. Being sensitive to trends both at home and in the foreign field, they plan for the future and are unlikely to be surprised by future developments.

Both men, while friendly, courteous and affable, have few really intimate friends outside of their own family circles. They are able, fluent and versatile speakers who use short, direct and incisive sentences. The professionals assign to each a high rating for their television appearances. Their colleagues in the Senate evaluate Mr. Nixon to be better in debate and in unprepared speech making while Mr. Kennedy excels in the prepared speech.

Both men, being equally receptive to new ideas, surround themselves with brilliant, intelligent advisers from whom they demand accurate information and solid advice. They despise adulation and flattery. They are capable of the toughness so characteristic of the old-time political boss. Each is a man who makes his own decisions, after which he gives orders and expects obedience.

For several years both of these men—so gifted, so talented and so well qualified—have been driven by a burning desire to become President. In the pursuit of this eminent goal each is a coldly determined, hard and resourceful competitor. Whoever wins in November, the country will be blessed by a worthy holder of this high office, one who will be unlike any in the last century.

Differences In Policies

The great differences between these two candidates lie in the policies they would pursue. It is to be hoped that our citizens will learn that when they vote on November the eighth, they are supporting not an individual whose personal appearance pleases them, whose television performance charms them, whose promises satisfy them, or whose artistically created public image appeals to them; but they are supporting a philosophy of government. And they must further clearly understand that one of these two fundamentally dissimilar philosophies of government will inevitably pilot our Ship of State into the distant future on a fixed course which later may permit of but little alteration in either latitude or longitude.

It is a well-recognized, long-established practice of political parties to choose both the platform and the candidates with the greatest vote-getting appeal. It is also to be expected that the individual candidates will exploit such planks from their platforms at such times and such places as may influence the greatest num-

**President's address presented at the 1960 KSMA Annual Meeting in Louisville on September 20, 1960.*

ber of voters. Both parties have embraced a political mystique that has overlain this country for a generation. This mystique assumes the form of the familiar dogma that any candidate must be "liberal" to win the Presidency. It arises from the assumption that a generation of repeated propaganda seems to have persuaded great bodies of our people that the liberal philosophy—call it socialism, statism, or what you will—is something America must embrace.

The ultra liberal platform of the Democratic party promises something to everybody. It accepts the idea that government can guarantee good times and is responsible for them. It would increase government spending to assure employment for all. It would repeal "anti-labor excesses which have been written into our labor laws." Programs to cost many billions are promised; for defense 2 to 3 more billion; for medical care an indefinite amount; for scholarships huge sums to assure a college education for all qualified; for school aid hundreds of millions to start with; for housing huge sums; for farmers new programs to take land out of use; and others with a total cost above 5 billions of dollars.

More Paternalism

This platform, which clearly leads to more paternalism, more spending in home affairs, more government intervention with a concomitant growth in bureaucracy, and a rapid increase in welfare expenses which today officially cost our government some 20 billion dollars for 12 months, does not explain how the proposed programs are to be financed. It simply suggests that the dollar is one more instrument of policy to be used when needed to guarantee prosperity; and that the money policy should be under the direct influence of the White House.

Senator Kennedy is pledged to make money plentiful and easy to borrow. In the simplest terms, this philosophy dictates that, if needed, the currency should be managed; and that controls, if required, would be applied to stop a run from dollars to gold.

The liberal conservative Republican platform also promises something for nearly everyone. It, too, would speed up the tempo of government and would accept a bigger role of government; but with some restraint. The promises are tempered by a pledge to avoid any further extension of government controls, to encourage the expansion of private enterprise in accordance with the tenets of the free American capitalistic system, and to keep government spending, if possible, within the limits of a balanced budget.

This philosophy believes that our money policy should not be under the influence of the White House, but should remain under the independent control of the Federal Reserve Board. The dollar should be "free": its value to be determined in the free world. Control or restrains on the flow of gold by direct means would be avoided, and the dollar would stand on its own feet. In the final analysis, this is the one and only true value assigned to it by all the rest of this world.

Sound Dollar Essential

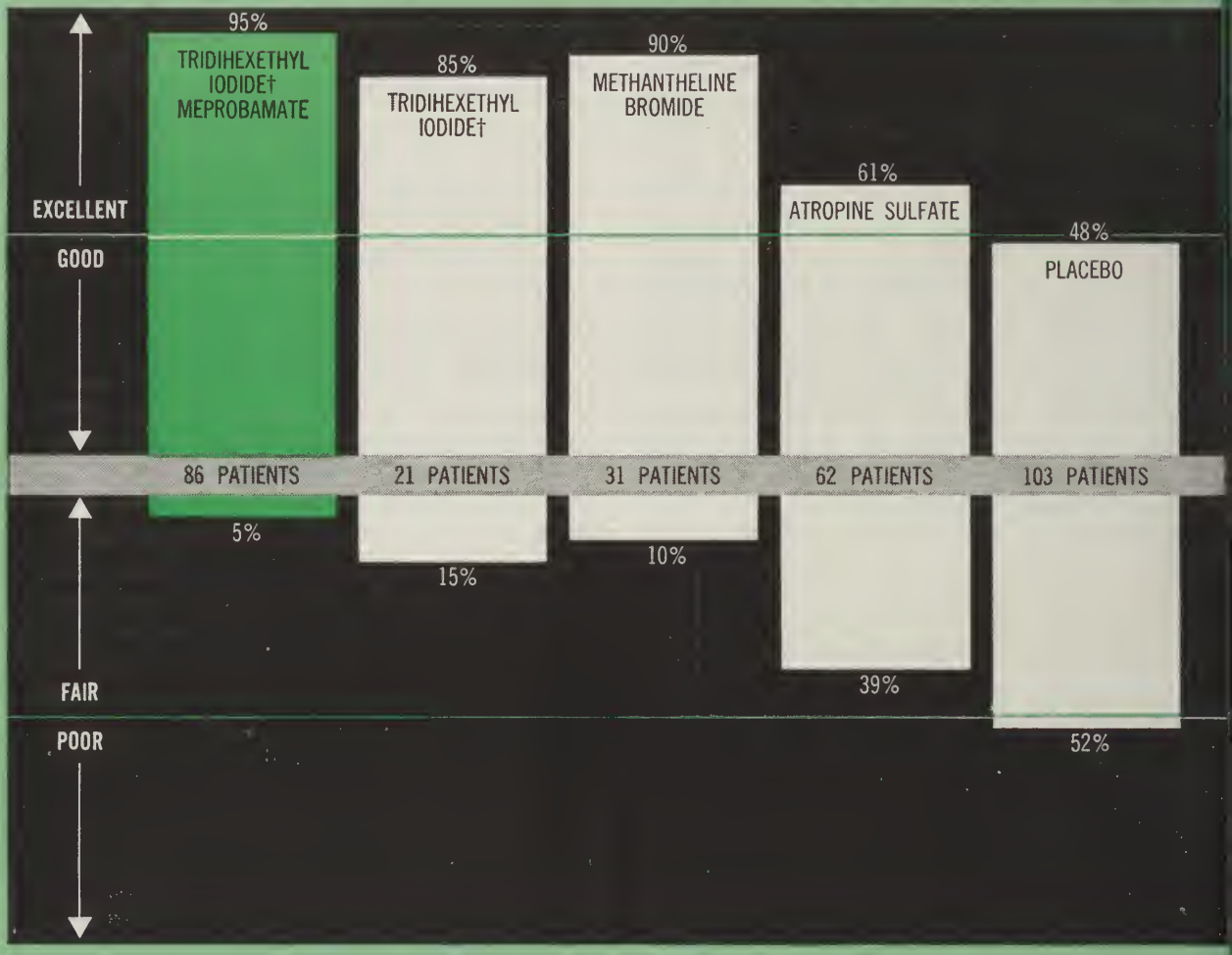
National health, national growth, national development and national security are based upon and are dependent upon a sound dollar and an abundant supply of currency. When President Eisenhower leaves office, the Federal Government will be spending dollars at the rate of 96.3 billions for each fiscal year. 45.9 billions or 47.6 per cent of this total outflow is going for defense. The flow of cash into and out of the Federal Treasury has become stupendous and now affects everybody and everything. The only source of Federal revenue is the taxpayer's dollar and every American citizen has a personal, legitimate interest in a sound, firm dollar. There are four cardinal reasons why this should be so.

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DRY MOUTH	1%	5%	72%	46%	5%
STOMATITIS	1%	0%	28%	14%	0%
VISUAL DISTURBANCES	0%	0%	50%	34%	1%
URINARY RETENTION	0%	0%	18%	11%	1%
DROWSINESS	20%	0%	0%	0%	0%
COMPLICATIONS OR SURGERY					
HEMORRHAGE	0%	9%	3%	9%	10%
PERFORATION	0%	0%	0%	6%	0%
OPERATION	0%	5%	5%	14%	2%
RECURRENCES					
NONE	28%	23%	25%	17%	26%
FEWER AND MILDER	67%	62%	52%	37%	24%
SAME OR MORE	5%	15%	23%	46%	50%

*Atwater, J. S., and Carson, J. M.: Therapeutic Principles in Management of Peptic Ulcer. Am. J. Digest. Dis. 4:1055 (Dec.) 1959.

†PATHILON is now supplied as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could distort the results of certain thyroid function tests.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

control the tension — treat the trauma

is required by law to maintain a balance of 11.9 billion in gold as a reserve against currency and deposit. Just so long as there is world-wide confidence in the soundness of our dollar, this gold problem, which is very real and very much alive, remains only potentially dangerous.

Perhaps we have forgotten that on September 21, 1931, England was forced to suspend gold payments. Within six weeks, 725 million dollars of our nearly 5 billion dollars gold supply—over 40 per cent of the world's entire monetary stock — was exported. During the next six months over 18 hundred banks with more than 1300 million in deposits failed. Again confidence in the soundness of our dollar was shaken; and during May and June another 450 million in gold was exported, driving our gold reserve below 4 billion dollars. This flight from the dollar to gold ceased abruptly at this time, only because all foreign claims against U. S. gold had been paid in gold.

Currency

II. Our currency. Perhaps we have also forgotten the "Inflation Act" on May 12, 1933. Under Section I of this Act, President Roosevelt on January 31, 1934, raised the price of gold from $20.7 per fine ounce to $35, thus effecting a dollar devaluation of 40.94 percent. Our present currency is based on this value.

Gold certificates, called representative money, have been issued since 1934 by the Treasury to Federal Reserve banks to serve as their monetary reserve. Each gold certificate has a 100 per cent gold reserve behind it.

Silver certificates are also representative money, for they are supposed to represent an equal value in silver. However, the face value of the bills being greater than the bullion value behind them, they are accepted at their face value on the credit of the United States.

Credit money is the major type of paper currency. Federal Reserve notes are backed by 25 per cent in gold certificates; the remainder consists of promissory notes belonging to banks and businessmen and of the United States government securities. The United States note is secured by a partial gold reserve and by the credit of the government, and Federal Reserve bank notes are secured by government bonds and national bank notes.

Thus our paper money is backed by 25 per cent in gold certificates and 75 per cent by paper which retains its full value only so long as there exists world-wide confidence in the soundness of the Federal Government's fiscal policies. An international loss in confidence of our dollar's value would soon transform the potential dangers in our gold supply situation into actual, critical ones.

Inflation

III. Inflation. While we have not experienced periods either of acute or transitory inflation, the erosion of the purchasing power of our dollar goes serenely and steadily on. During the last decade alone the cost of living, which has increased 24 per cent, has destroyed 20 per cent of our 1950 dollar's purchasing power. In the January 13, 1942, issue of a popular weekly magazine appeared an insurance ad under the heading, "How I Retired on a Life Income of $150 a Month." In the January 14, 1952, issue of the same magazine a similar ad was run, but the heading had been changed to, "How I Retired in 15 Years with $200 a Month." By January, 1954, the heading of the ad was changed to, "How I Retired in 15 Years with $250 a Month"; and by February of 1956, the amount of the monthly check had risen to $300. A couple could live fairly comfortably during February of 1956 on $300. Could they do so today?

Taxes

IV. Taxes. The total revenue of the Federal Government is derived from the taxpayer's dollar. Should deficit spending occur over a long period of time, additional revenue becomes necessary, and one means of raising this is to increase income taxes. The incomes of very wealthy people are taxed at 90 per cent above a level of $300,000. Considering the limited number of such people, no appreciable sum is to be realized from this source. Corporations are now paying 52 per cent of their earning to the government. Since increasing this rate would soon impair the earning power of such corporations, no additional revenue can be obtained from this source. The Tax Foundation reports that people with incomes from $2,000 to $15,000 yearly pay 70 per cent of the total tax bill. If higher income taxes ever become

necessary, only the average American citizen remains to pay the bill.

A clear understanding of each plank in each platform must exist before an intelligent decision on voting can be reached. The Medical and Health Care for the Aged problem is a major political issue both now and tomorrow. Either party has taken a clear, firm, unequivocal position. It is now imperative that all of the voters should understand both all of the terms used and their implications.

Early in the 86th Congress, Senator Kennedy introduced into the Senate the Kennedy Bill, a plan to provide health care of the aged under the Social Security mechanism. He has consistently and actively supported this viewpoint prior to the Democratic Convention where it was incorporated into the party platform, and continued his support throughout the post-convention portion of this Congress. Although this type of plan was finally rejected by this Congress, it is certain that similar legislative struggles will arise in the next Congress, and that Senator Kennedy's convictions will remain unchanged.

Compulsory Health Insurance

Health care for the aged under the Social Security system means compulsory health insurance. Once any group of our senior citizens is covered by such a plan, in each successive election year this plan will be liberalized until all the people are included. The Supreme Court of the United States has observed, "it is scarcely due process for government to regulate that which it subsidizes." And so, if the government pays the bill, government must regulate the health care it buys with public funds. This is socialized medicine.

During his 14 years in Congress, Senator Nixon has consistently emphasized voluntary over compulsory action in this field. President Eisenhower spoke against compulsory health insurance in June, 1959, and the Administration has evenly maintained this position. The Republican Platform recognizes that some of our senior citizens can not afford medical care. It proposed that the Federal Government should provide on a federal-state-cost sharing plan the funds necessary to meet this need. Such a plan is the final form of H. R. 12580 which is now law. This is not compulsory health insurance; it is not socialized medicine.

The quality of medical care developed under the free enterprise system and existing throughout this country is of the finest, and is available at all times to all of our people. The individual remains free to choose his own physician, to enter his own hospital, and to do this whenever he pleases.

Critical Years Ahead

The next four years will be critical ones. The issue will continue to be peace and prosperity. Both parties are needed to maintain our unique but effective political system of government. Their function is to furnish both the platform and the candidates to run on them. The candidates are practical professional politicians who are specialists in the Science and Practice of Government. Some specialize in making the laws and some in administering them.

Almost all the rest of our citizens are largely content with voting for or against these dedicated men. Indeed, a great many do not even do that much. The privilege of voting is a priceless heritage. It is also a civic and moral responsibility. The time has come when every citizen eligible to vote must identify the political philosophy which, in his or her opinion, offers most to the future of this country, must give his full support to the candidates of his own choice, and then on November 8 must vote in accordance with his personal convictions.

EDITORIALS

Kentucky AMEF Campaign

OUR daily mail carries a constant chain of appeals for worthy causes and, though we'd like to support all of them, we must select a few to head our philanthropy list.

One appeal we should answer is the request for financial aid to medical education. This aid can be given through AMEF, or directly to your medical school.

Your gift to AMEF accomplishes many things. Your dollars help to offset the $10,000-000 annual operating deficit of our medical schools. Your dollars deny the need for federal aid to medical education. Your dollars illustrate to others the concern of the medical profession over the financial plight of its schools, and help pay back the 80 per cent of the cost of your education which tuition did not pay.

Formerly, large private estates were the key sources of philanthropy for education; these no longer exist, with few exceptions. Inheritance and income taxes have done an effective job in exterminating these fortunes. Industry has replaced this source and today is the greatest potential source of private philanthropic support of education. The National Fund for Medical Education annually receives two million dollars from firms and corporate foundations, most of whom have a vested interest in a free future of American Medicine.

We must help if we are to be assured a free profession in the future and one that looks to those in the practice of medicine for its standards rather than to the politician.

Join with the thousands who are supporting medical education through the American Medical Education Foundation.

Claude C. Waldrop, M.D.

Time For Action

THE American Medical Profession in general has felt a sense of profound relief in the failure of the last Congress to enact the Forand Bill for medical care of the aged or any radical Forand type of legislation. We must admit that this was a rather unexpected turn of events. It seemed that the very political expedience which made the passage of such legislation almost certain was the factor which led to moderation in the final decision.

We as a State Medical Association are grateful that our Kentucky Senators on the 23rd of August voted for the Mills bill and voted against those amendments which would tie this legislation to social security. The form of legislation which was finally passed was undoubtedly that which is most acceptable to the medical profession at large.

While we are grateful for this favorable development, we dare not be complacent. It is generally believed that in the next Congress vigorous efforts will be undertaken to expand the provisions of medical care for the aged and to tie it to social security. Fortunately the White House Conference, scheduled to meet in January to consider the problems of the aging population, will have deliberated and reached some recommendation before the next

Congressional session begins. That Congress will undoubtedly be influenced by the findings of the White House Conference.

We in Kentucky have reason to be pleased with the actions taken and the resolutions passed at the preliminary governor's conference held at the University of Louisville on September 2nd and 3rd, 1960. We would be happy if the decisions expressed at that conference could be carried with some effect to the White House Conference in Washington.

Now that we have a period of time in which to work, what can we do to maintain the position already taken on the matter of medical care for the aged?

First, we as representatives of our State can carry to the White House Conference the clear statement of our position as citizens and physicians in Kentucky.

Second, we can strive by every means possible to perfect our own system of indigent medical care, of which the federal medical care of the aged becomes now an integral part. We have very little precedent by which to pattern such a plan, but we do know what we want to accomplish with the funds available, and we should continue to strive in cooperation with our committee on indigent medical care to build as effective and efficient a plan of operation as possible.

Third, we are fortunate in Kentucky that the management of Blue Cross and Blue Shield has remained largely under the guidance of physicians themselves. The directors of our Blue Cross-Blue Shield Plan are far more tolerant of and cooperative with the aims of the medical profession than in most of the 68 plans across the country.

Dr. Vincent Pierce has done a remarkably fine piece of work in outlining and directing a sound course for our Blue Cross and Blue Shield Plan. He and those others aligned with him will continue to seek to improve and expand prepaid medical care plans in this state. We as individual citizens must cooperate.

It is generally believed that prepaid health insurance more than any other single force holds the key to the direction of medical care plans in the immediate future. These bodies individually and nationally are presented with the challenge which, if met, may hold the line and even regain some of the ground that has been lost to socialization of medical care. The failure to take advantage of our present opportunity is bound to spell disaster.

Sam A. Overstreet, M.D.

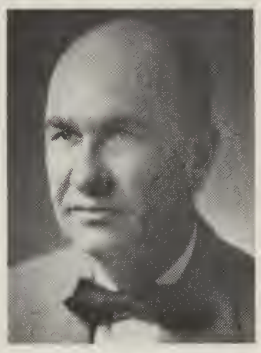
Truth and, by consequence, liberty, will always be the chief power of honest men.

—Madame de Stael

ORGANIZATION SECTION

Dr. Simpson Of Greenville Named KSMA President For 1961-62

Gaithel L. Simpson, M.D., Greenville surgeon, was named president-elect of the Kentucky State Medical Association by unanimous vote of the House of Delegates on September 21 at its final session of the 1960 Annual Meeting in Louisville.



Dr. Simpson

He will take office next year, succeeding Richard G. Elliott, M.D., Lexington.

Doctor Simpson was vice-president (Western) of KSMA in 1935-36 and councilor of the Third District from 1948 to 1950. He served as chairman of the KSMA's Committee on Medical Education and Economics from 1952 until the present.

Closely associated with Kentucky's indigent medical-care program since its inception in 1952, he recently was elected chairman of the Governor's 11-member State Advisory Council on Medical Assistance. He has also served the State as a member of the Hospital Licensure Council and the State Board of Health.

In 1955, Doctor Simpson received an award from the American Cancer Society, primarily for his service as director of the Muhlenberg Community Hospital cancer clinic. A native of Christian County, he has practiced in Greenville since 1932.

Vice-presidents elected at the September 21 meeting were: Foster D. Coleman, M.D., Louisville (Central); Wendell V. Lyon, M.D., Ashland (Eastern); James T. Gilbert, M.D., Bowling Green (Western).

Robert C. Long, M.D., Louisville, was renamed KSMA delegate to the AMA for a three-year term and George P. Archer, M.D., Prestonsburg, was re-elected alternate delegate.

Nominating Committee Chosen

The five-member Nominating Committee elected for the 1961 Annual Meeting of KSMA has been announced by Speaker of the House Sam A. Overstreet, M.D., Louisville.

A list of 10 names was submitted to the House of Delegates at its final session September 21, with the highest number of votes going to: A. D. Butterworth, M.D., Murray; M. C. Darnell, M.D., Lexington; Russell L. Hall, M.D., Prestonsburg; William E. Oldham, M.D., Louisville, and Walker M. Turner, M.D., Paducah. Under the KSMA Bylaws, the committee will meet to elect a chairman at the County Society Officers Conference to be held next April in Lexington.

Dr. Stevenson and Dr. Norvell Head KSMA Board

J. M. Stevenson, M.D., Brooksville, is the newly-elected chairman of KSMA's Board of Trustees (which was the Council until Monday night, September 19, when the House of Delegates voted to change the Constitution).



Dr. Stevenson

Councilor of the Ninth District since 1953, he served as vice-chairman of the Council last year. He succeeds Carlisle Morse, M.D., Louisville, trustee from the Fifth District, who was named to the Executive Committee.

Doctor Stevenson has been active in medical and community affairs for many years. He is the present secretary of the Bracken County Medical Society.

Elected vice-chairman of the board was Wyatt Norvell, M.D., New Castle, trustee from the Seventh District. Doctor Norvell is chairman of the KSMA Legislative Committee for State Affairs. In addition, he has served as chairman of the KSMA Rural Health Committee and as chairman of the Kentucky Rural Health Council.

At the board's reorganization meeting, Thomas O. Meredith, M.D., Harrodsburg, trustee from the Twelfth District, was named to the Executive Committee along with Doctor Morse.

Dexter Meyer, M.D., Covington, was elected by the House to succeed Norman Adair, M.D., Covington, as trustee from the Eighth District. Hubert C. Jones, M.D., Berea, was chosen to succeed Joe M. Bush, M.D., Mt. Sterling, in the Eleventh District.

Re-elected to the board were: Doctor Morse, Fifth District; John P. Glenn, M.D., Russellville, Sixth District, and Keith P. Smith, M.D., Corbin, Fifteenth District.

Douglas Scott, M.D., Lexington, was named to serve the one-year unexpired term of former Councilor, Richard G. Elliott, M.D., Lexington, new KSMA president.



OATH OF OFFICE—Richard G. Elliott, M.D., left, Lexington, was sworn in as president of the Kentucky State Medical Association on September 21 by Carlisle Morse, M.D., Louisville, chairman of the Board of Trustees.



FIRST DUTY—As his first official act, Doctor Elliott presented the Past President's key to the retiring president, Irvin Abell, Jr., M.D., Louisville. The change in presidents took place at the second meeting of the House.

1,021 KSMA Members Registered At 1960 Annual Meeting

With registration of 1,021 members, the 1960 Annual Meeting went on record as the second-best attended session of KSMA. Representing 50 per cent of the Association's membership, the figure was topped only in 1957 when 1,094 were present.

Total registration was 2,014, including guest physicians, interns and residents, medical students, registered nurses, technicians and office assistants, exhibitors and guests.

Interest in the scientific sessions ran unusually high; this was attributed to the high quality of the program. Specialty group meetings were crowded and extra seats had to be provided for some sessions.

Specialty Groups Elect

Rudy J. Ellis, M.D., Louisville, was elected president of the **Kentucky Orthopaedic Society** at its annual meeting in Louisville September 21. He succeeds William K. Massie, M.D., Lexington.

The Kentucky Chapter of the **American College of Chest Physicians** elected William H. Anderson, M.D., Harlan, as its 1960-61 president. He succeeds Oren A. Beatty, M.D., Hazelwood.

25 New Members Of KSMA Attend Luncheon In Their Honor

The KSMA's second annual luncheon honoring new members was attended by 25 physicians who joined the association during the year beginning September 1, 1959. The luncheon, held at the Brown Hotel on September 20, was a feature of the opening day of the 1960 Annual Meeting.

The purposes and services of KSMA were explained to the new members by a panel of four physicians headed by N. Lewis Bosworth, M.D., Lexington, chairman of the Association's Committee on Public Information and Services. The other participants were: Carl H. Fortune, M.D., Lexington; Hoyt Gardner, M.D., Louisville, and Wyatt Norvell, M.D., New Castle.

Guests at the luncheon included five officers of KSMA: Irvin Abell, Jr., M.D., Louisville, outgoing president; Richard G. Elliott, M.D., Lexington, incoming president; Woodford B. Troutman, M.D., Louisville, secretary; Delmas M. Clardy, M.D., Hopkinsville, treasurer, and Carlisle Morse, M.D., chairman of the Board of Trustees.

The new members termed the meeting a worthwhile and enjoyable occasion.

COMPARATIVE REGISTRATION FIGURES
KSMA Annual Meetings

	1951*	1952	1953	1954	1955	1956	1957	1958	1959	1960
KSMA Members	**846**	**693**	**786**	**924**	**938**	**923**	**1094**	**971**	**997**	**1021**
Guest Physicians	138	67	75	150	122	157	178	166	165	203
Interns-Residents	101	73	100	148	106	105	142	108	128	105
Medical Students	330	252	292	284	299	305	328	269	280	289
Registered Nurses	27	16	31	25	55	15	28	22	34	25
Exhibitors	204	180	153	174	174	218	176	211	200	239
Guests	189	80	72	166	121	108	151	164	86	99
Technicians—										
Office Assistants	76	49	54	67	50	54	54	45	63	33
TOTAL ATTENDANCE	**1911**	**1410**	**1563**	**1938**	**1865**	**1885**	**2151**	**1956**	**1953**	**2014**

*KSMA Centennial



DISTINGUISHED SERVICE MEDAL winner for 1960, George P. Archer, M.D., right, Prestonsburg, is congratulated by KSMA secretary, Woodford B. Troutman, M.D., Louisville.



OUTSTANDING GP, John B. Rypstra, M.D., right, Annville, proudly shows his citation to his wife and Robert E. Pennington, M.D., London, who nominated him for award.



R. HAYNES BARR AWARD recipient, David Layne Tynes, right, Louisville, receives his plaque from Doctor Troutman, who made the presentation of the KSMA honors at the President's Luncheon on September 21.

Three KSMA Awards Presented At President's Luncheon

The Kentucky State Medical Association bestowed its top physician honors for 1960 on two Eastern Kentucky doctors—George P. Archer, M.D., Prestonsburg, receiving the Distinguished Service Medal and John B. Rypstra, M.D., Annville, the Outstanding General Practitioner Award.

The R. Haynes Barr Award, given each year to a lay person for outstanding contributions in the field of public health and medical care, went to David Layne Tynes, executive director of Physicians Mutual, Inc., in Louisville.

The awards were presented at the annual President's Luncheon at the Brown Hotel on September 21. Woodford B. Troutman, M.D., Louisville, secretary of KSMA, made the presentations.

Medical, Civic Leader

Doctor Archer has been a leader in medical and community activities for many years. As chairman of the KSMA's Legislative Committee on National Affairs, he has been an outspoken foe of third-party, Forand-type legislation and a staunch supporter of free choice of physician. In this connection he has appeared before Congressional committees and various AMA committees. He has served the KSMA as alternate delegate to the AMA, was the first secretary and 1958 vice-president of the Kentucky Academy of General Practice, and is a past president of the Floyd County Medical Society.

The Prestonsburg physician was named an outstanding young man of the year by the Kentucky Chamber of Commerce in 1948-49. He is a past president of the Prestonsburg Kiwanis Club and a former member of the city's School Board.

A native of Paintsville, Doctor Archer was graduated from the University of Louisville School of Medicine in 1941 and started practice in Paintsville in 1946 after serving in the U. S. Air Force with the rank of major. The next year he moved to Prestonsburg.

Only Doctor In County

At 37, Doctor Rypstra is the youngest physician ever to receive the KSMA General Practitioner Award. Until several months ago he was the only doctor in Jackson County, serving a population of 10,000 persons. He has been called "as much a missionary to the people of that area as Dr. Thomas Dooley is to the people of Southeast Asia, under conditions almost as trying." He travels by jeep and, when necessary, by foot to reach patients.

Born in Muskegon, Mich., Doctor Rypstra received his medical degree from the Indiana University Medical School in 1947. While practicing in Indianapolis, he was persuaded by the Reformed Church of America, which operates Annville Institute, a mission school at Annville, to move there in 1949.

Last April he was honored by the Jackson County Kiwanis Club and the Women's Club at a testimonial dinner in appreciation of his outstanding service to the area.

(Continued on Next Page)



PRESIDENTIAL TRIO—Newly-installed KSMA president, Richard G. Elliott, M.D., left, Lexington, and the new president-elect, Gaithel L. Simpson, M.D., center, Greenville, accept a word of admonition from retiring president, Irvin Abell, Jr., M.D., Louisville. The picture was made Wednesday night, September 21, at the close of the second meeting of the House.

KSMA Awards Presented

(Continued)

Mr. Tynes, a native of Texas, helped organize the Blue Cross Plan in Kentucky in 1938 and the Blue Shield Plan in 1949. He is the first executive officer of both organizations.

In presenting the R. Haynes Barr Award, Doctor Troutman complimented Mr. Tynes for his "outstanding contribution in helping the people of Kentucky to finance health care and in demonstrating that most of Kentucky's people can obtain medical care outside the framework of government and in a voluntary manner."

Mr. Tynes has served on the Governor's Committee on Indigent Care, and has held numerous offices with the National Blue Cross organization.

Mrs. Guy Morford Of Owensboro Elected By KSMA Auxiliary

Mrs. Guy Morford, Owensboro, was named president-elect of the Woman's Auxiliary to the Kentucky State Medical Association at the group's 38th annual meeting in Louisville, September 20-22.

Mrs. Earl W. Roles, Prospect, was installed as president, succeeding Mrs. Charles B. Johnson, Russell.

Other officers elected were: First vice-president, Mrs. Hugh Mahaffey, Richmond; second vice-president, Mrs. C. I. Haeberle, Russell; third vice-president, Mrs. John Y. Barbee, Bowling Green; fourth vice-president, Mrs. Keith Smith, Corbin; recording secretary, Mrs. John B. Floyd, Lexington; corresponding secretary, Mrs. Thomas E. Booth, Louisville; treasurer, Mrs. R. O. C. Green, Bowling Green.

Mrs. J. H. Calvert, Pikeville, received the auxiliary's health-citation award, given annually to the layman or lay organization for outstanding health work. She has been active in the field of mental health.

Golf Trophies Go To Drs. Royalty, Fowler and Overstreet

Two Lexington physicians and one from Paducah captured the trophies in the Kentucky State Medical Golf Association's 1960 Tournament, announces William C. Wolfe, M.D., Louisville, chairman of the KSMA Golf Committee. Forty-one physicians registered at the Louisville Country Club to participate in the event held September 20-22 in conjunction with the Annual Meeting.

The winners were:

Championship cup (Low Greens)—D. M. Royalty, M.D., Lexington.

Low net cup—Merle Fowler, M.D., Paducah.

Senior championship cup—T. J. Overstreet, M.D., Lexington, winner for the third consecutive year.

Runner-up in the low net division was William C. Roland, M.D., Ashland. (Four physcians had identical scores in this category, but Doctor Roland was awarded the prize because he had the lowest handicap).

The winners received other prizes in addition to the trophies. They keep possession of these traveling trophies until new championships are determined in the 1961 tournament.

KSMA House Makes Far-Reaching Policy Decisions
In One Of The Most Important Sessions In Its History

In one of the most harmonious sessions on record, the House of Delegates of the Kentucky State Medical Association made a number of far-reaching policy decisions in the two busy sessions, September 19 and 21, held during the 1960 Annual Meeting in Louisville.

The House voted to endorse the roads and parks bond issue, reaffirmed its support of the limited convention for the revision of the constitution for the State of Kentucky, revised its own constitution, and reconstructed its committee set-up through bylaw change. The House also accepted the report of the Committee to Study a New Home for the Headquarters Office of KSMA.

Speaker of the House Sam A. Overstreet, M.D., Louisville, said that complete records of the 43 reports and six resolutions submitted to the House, the reference committee recommendations on each report and resolution, and the action of the House would appear in the December issue of *The Journal* Also, in the same issue will be the rewritten constitution and bylaws of KSMA as accepted by the 1960 House.

Board Replaces Council

For the first time, the seven reference committees of the House held their meetings in the new air-conditioned Sunday School rooms of First Christian Church, one-half block from the Columbia Auditorium. The House voted to thank the church for this convenience and service.

The House, in accepting the recommendations of the Committee to Study the Constituion and Bylaws, has provided for the reorganization of the KSMA committee structure, streamlining it and making it more effective. Included in the revison was the changing of the name of the Council, the Association's interim governing body, to the Board of Trustees. This frees the word "council" to be used in regrouping organization of the committees.

The House passed without a dissenting vote the proposal of the Committee to Study the New Home for the Headquarters Office. (See story and picture of proposed site of the new building elsewhere in this issue).

Groups Commended

Reference Committee No. 1 called attention to the report of the Council (now Board of Trustees) and commended it for the volume and manner in which it had handled its work during the year. It was noted that with a bit of extra effort the KSMA could qualify for a third delegate to the AMA. It also commended the KSMA delegates to the AMA for the excellent services performed.

In other actions, the House voted to accept the report of the Legislative Committee for state and national affairs and expressed its appreciation for the work done. The House thanked the Committee on Medical Education and Economics for its good work in the various activities including the indigent Medical Care Program in which it engaged.

The report of the Committee on Public Information and Service was accepted with appreciation; however, the House felt that the matter of giving its endorsement to establishment of a Kentucky Chapter of the American Medical Assistants Association should be given further study.



SPEAKER OF THE HOUSE Sam A. Overstreet, M.D., right, Louisville, introduced James Archer, M.D., Paintsville, chairman of the Nominating Committee, at the second session of the House. E. Gaines Davis, Frankfort, legal counsel for KSMA, is seen in the background.

The report of the KSMA Advisory Commission to Blue Shield was commended and noted with pleasure the continuing progress of Kentucky Physicians Mutual, Inc., the Blue Shield Plan for Kentucky.

The splendid services of the Physicians Placement Service and the Rural Kentucky Medical Scholarship Fund to the people of Kentucky were highly commended. The House urged KSMA members to take more interest in voluntary health organizations.

KSMA Makes Recommendations On Indigent Medical Care

The KSMA Technical Advisory Committee to the Indigent Medical Care Program of Kentucky presented its recommendations to the State Advisory Council on Medical Assistance at a meeting in Frankfort October 10. Its views pertaining to hospitals, physician services, drug administration and dental care were formulated at two previous meetings of the committee, which is headed by Clyde C. Sparks, M.D., Ashland.

Also making their recommendations were four allied groups—the Technical Advisory Committees on Dental Care, Drugs, Hospital Care, Nursing and Home Care.

The State Advisory Council decided it needed time to consider the proposals and postponed action until its next meeting October 24 and 25. G. L. Simpson, M.D., Greenville, is chairman of this 11-member group.



ALLIED GROUPS RECOGNIZED—Presidents of allied groups were given a warm reception at the President's Luncheon by KSMA president, Irvin Abell, Jr., M.D., Louisville. From left: Mrs. Elizabeth Perry Baxter, Louisville, State Nursing Home Association; Gordon Bell, Lexington, Kentucky Medical Technologists; J. J. Thompson, South Fort Mitchell, Kentucky Pharmaceutical Association; Ed J. Buechel, D.D.S., Louisville, Kentucky Dental Association; Mrs. Lola Belle Akin, Paintsville, Kentucky State Association of Registered Nurses, and Malcolm Black, Glasgow, Kentucky Hospital Association.

Medical Editors Conference Draws 65 From 27 States

The third Regional State Medical Editors Conference, held October 15 and 16 in Lexington, attracted medical editors from coast to coast. Sixty-five persons from 27 states and the District of Columbia registered for the meeting at which *The Journal* of KSMA was host.

Guest speakers included Austin Smith, M.D., Washington, D.C., president of the Pharmaceutical Manufacturers Association; Alfred J. Jackson, Chicago, president of the State Medical Journal Advertising Bureau, and Edmund Pellegrino, M.D., Lexington, professor and chairman of the Department of Medicine, University of Kentucky Medical Center.

Prof. J. A. McCauley, of the U. of K. School of Journalism, served as a consultant to the editors in group and individual interviews. The program also featured three panels on problems of medical journals.

A high light of the meeting was a tour through the new $27,000,000 University of Kentucky Medical Center, conducted by William R. Willard, M.D., vice-president of the Center and dean of the College of Medicine, and members of his staff. Following this, the members of the conference were guests of Doctor Willard and Mrs. Willard at a cocktail party and dinner at their home in Lexington. As a climax to the day, the visitors were taken to the University stadium where they saw the U. of K. football team defeat the Louisiana State University.

The Journal's editor and associate editor, Sam A. Overstreet, M.D., and George W. Pedigo, M.D., Louisville, presided at the various sessions of the conference. The scientific editor, Jack L. Chumley, M.D., Louisville, gave a wrap-up of the program.

Program For Third Norton Seminar Dec. 15 Is Announced

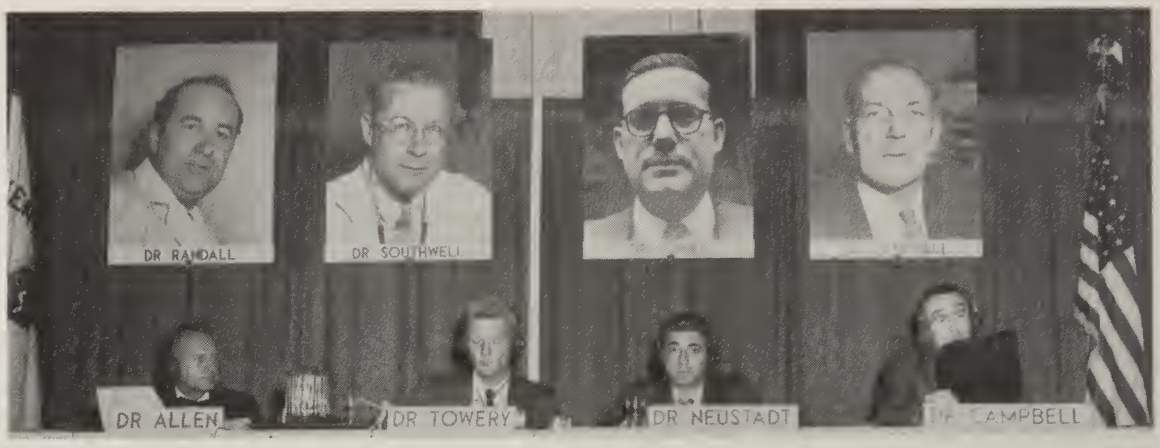
Nineteen physicians are listed on the program of the third annual Norton Memorial Infirmary Postgraduate Medical Seminar set for December 15 at the Infirmary in Louisville. Cosponsor is the Kentucky Chapter, American Academy of General Practice.

The seminar will open at 10 a.m. with a presentation, "Office Cytology," by William Christophersen, M.D., Louisville. This will be followed by a symposium on "Acute Abdominal Crises," with George B. Sanders, M.D., Louisville, as moderator and the following Louisville physicians as discussants: Henry S. Collier, M.D.; Will W. Ward, Jr., M.D.; Lawrence T. Minish, Jr., M.D.; Lonnie W. Howerton, M.D.; Laman A. Gray, M.D.; Ludwig H. Segerberg, M.D.; Allen F. Zoeller, M.D.; Benjamin B. Jackson, M.D., and W. Burford Davis, M.D. Malcolm L. Barnes, M.D., Louisville, will serve as chairman of the morning session.

An address, "Medicine and the Law" by Harry W. Ginty, Fort Wayne, Ind., will start the afternoon program. Mr. Ginty is secretary and chief of the legal department of Medical Protective Company.

Essayists for the afternoon session and their subjects will include: Wyatt Norvell, M.D., New Castle, "Education of the Rural Physician"; David W. Kinnaird, M.D., Louisville, "Vagotomy Today"; Arthur M. Schoen, M.D., Louisville, "Gastritis"; A. B. Loveman, M.D., Louisville, "Griseofulvin in Superficial Mycoses" (Kodachrome demonstration); Robert Lich, Jr., M.D., and Lawrence A. Davis, M.D., Louisville, "Childhood Upsets." John G. Archer, M.D., Louisville, will be the afternoon chairman.

The course has been accepted for 5 hours of Category I credit.



SPANNING THE SEA—This was the scene at the Columbia Auditorium in Louisville September 21, when a KSMA panel exchanged views on collagen diseases with a team of physicians in Britain. The hour-long telephone conference—first of its kind ever staged by a state medical association—was a high point of the 1960 Annual Meeting. The KSMA panel included three Louisville physicians, from left; John D. Allen, Jr., M.D.; Beverly Towery, M.D., moderator; David H. Neustadt, M.D. The fourth member was John A. Campbell, M.D., Indianapolis. Large photographs of their British counterparts were posted behind them, and a light flashed on under each British doctor's picture when he spoke.

Dr. Troutman On Group Named To Promote Revision

Woodford B. Troutman, M.D., Louisville, secretary of the Kentucky State Medical Association, was one of 48 persons appointed last month by Governor Combs to an advisory group to promote the calling of a constitutional convention.

Mrs. J. Andrew Bowen, Louisville, was named to represent the Women's Auxiliary to KSMA.

Appointed from allied groups were E. Murphy Josey, Frankfort, executive secretary of the Kentucky Pharmaceutical Association, and Dr. R. P. Thomas, Louisville, Kentucky Dental Association.

KSMA Well Represented On Program Of SMA In St. Louis

A number of Kentucky physicians were scheduled to appear on the program of the Southern Medical Association's 54th annual meeting in St. Louis, October 31-November 3.

Albert H. Joslin, M.D.; Robert Lich, Jr., M.D., and Malcolm L. Barnes, M.D., Louisville, were guest speakers for the Section on Urology. "Unsuspected Carcinoma in Surgical Specimens of the Prostate" was the subject of their presentation.

W. K. Massie, M.D., Lexington, addressed the Section on Orthopedic and Traumatic Surgery on "Treatment of Extracapsular Fractures of the Femur Based on Bio-Mechanical Principles Using a Sliding Nail Technique."

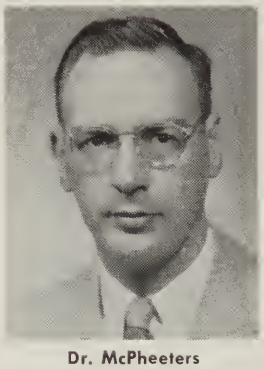
Carroll L. Witten, M.D., Louisville, as chairman of the Section on General Practice, opened a discussion on "Disaster Mobilization."

"Cesarean Section: A Six-Year Review" was the title of a paper given before the Section on Obstetrics by Douglas M. Haynes, M.D., and Hershel Clemmons, M.D., Louisville. A third Louisvillian, Silas H. Starr, M.D., opened the discussion. John D. Gordinier, M.D., Louisville, was chairman of the section.

Madison Cawein, M.D., Lexington, an essayist for the Section on Medicine, read a paper, "Study of Anemia of Hepatic Disease Utilizing Radiochromium."

Dr. McPheeters Honored For Service In Mental-Health Field

Harold L. McPheeters, M.D., Louisville, State Commissioner of Mental Health, was honored October 5 by the Kentucky Association for Mental Health as the "individual who has done the most for mental health in Kentucky" in 1960. He was awarded an outstanding-service plaque.



Dr. McPheeters

The presentation, made at the association's annual meeting in Louisville, was by a former State Commissioner of Mental Health, Frank Gaines, M.D., who is now assistant dean of the University of Louisville School of Medicine.

Doctor McPheeters was cited "most particularly for his devotion and dedication to a program which has meant a better day for some 6,000 to 7,000 Kentuckians." This dedication, the citation said, has won him the respect and support of two governors and two administrations.

Louis M. Foltz, M.D., Louisville, was elected second vice-president of the association. John Bell, M.D., Louisville, was named a new director and Doctor McPheeters and Hollis Johnson, M.D., also of Louisville, were elected exofficio directors.



SITE OF NEW HOME—The location of the property on which KSMA's proposed new home will be erected is indicated by the white X on this airview of the intersection of the Watterson Expressway and Taylorsville Road in Louisville. This view of the Expressway interchange, taken soon after its completion, faces northeast and toward the Shelbyville Road.

Building Of New KSMA Home Authorized By Delegates

The KSMA will have a new Headquarters Office Building, located near the intersection of the Watterson Expressway and Taylorsville Road in Louisville, some time in 1961 as a result of the action of the 1960 KSMA House of Delegates.

Acting on the recommendation of the 1959 president, Robert W. Robertson, M.D., Paducah, and a resolution of the Muhlenberg County Medical Society, the House in 1959 authorized the activation of a committee to study a new home for KSMA. During the year, the committee held five meetings, three of them day-long sessions, in addition to making a three-day trip to visit the new headquarters office buildings in Mississippi, Alabama and Tennessee. Attendance was 100 per cent at each meeting of the committee.

Without a single objection, the House at its September 21 meeting accepted the report of this committee and the recommendations it made. Speaker Sam A. Overstreet, M.D., Louisville, called the report one of the most thorough and best prepared ever presented to the House. The committee is composed of George Brockman, M.D., Greenville, chairman; Lewis N. Bosworth, M.D., Lexington, and Hoyt D. Gardner, M.D., Louisville.

The Board of Trustees on September 21 voted to continue the committee as the Building Committee, authorized it to employ the firm of Nivin and Morgan, Louisville, as architects, and to proceed with the purchase of the lot and getting the program underway.

Subsequent issues of *The Journal* will report the progress of the work on the new structure. Doctor Brockman said his committee estimated the building program, including the time it would require to "iron out all the details, etc.," would be completed in 12 to 14 months.

Dr. Noer On ACS Program

Rudolf J. Noer, M.D., professor and chairman of the Department of Surgery at the University of Louisville School of Medicine, will take part in the program of the annual four-day Sectional Meeting of the American College of Surgeons in Philadelphia, March 6-9, 1961. He is scheduled as a participant in a symposium titled "Large Bowel, Including Diverticulitis and Polyps," to be presented at the opening day's afternoon session.

Fayette Society Host To U.K. Class

The Fayette County Medical Society entertained in honor of the first class of the University of Kentucky College of Medicine at a picnic at Loudon House, Castlewood Park, Lexington, on October 7. Seventy-five persons, including students, faculty members and medical society members, attended.

Keep Medicine Free In U. S., KSMA Speaker Urges

"I hope that England's future will not be yours. It (socialized medicine) is not good for the patient, not good for the physician and, ultimately, not good for the politician."

This was the warning sounded by a former British physician, John B. Reckless, M.B., in a challenging address before 250 KSMA members and guests at the 1960 President's Luncheon. Speaking on "The Facts of Life in the Future of American Medicine," he described the good and bad points of the National Health Service or "cradle-to-the-grave" program in his native country.

The most important advantage, he said, is that a patient need not fear bankruptcy in event of a catastropic illness.

The greatest evil, in his opinion, is the loss of the doctor-patient relationship "which is so vital to good medical care." Under socialized medicine, "the patient has a contact with the government, not with the doctor."

The speaker also cited the lack of hospital building in England and the large number of persons on hospital waiting lists. No new hospitals were started during the decade, 1948 (when the capitation program went into effect) to 1958, he said.



THE BRITISH SCHEME of medical care was explained at the President's Luncheon by a former British physician, John B. Reckless, M. B., now of the Duke University Medical Center.

In summary, Doctor Reckless had these words of advice for American physicians: (1) Stay away from government schemes; (2) avoid a capitation system; (3) keep saying "No" to politicians.

Since coming to this country in 1958, Doctor Reckless has been in the residency training program of the Department of Psychiatry at the Duke University Medical Center, Durham, N. C.



AT THE HELM—Irvin Abell, Jr., M.D., Louisville, presided at the President's Luncheon, which attracted a capacity attendance of KSMA members and guests.

18 Kentuckians New ACS Fellows

Eighteen Kentucky physicians were initiated as Fellows of the American College of Surgeons at the college's 47th annual Clinical Congress in San Francisco, October 10-14. They were among 1,170 surgeons initiated, bringing the total membership to 24,250.

Seven of the group are Louisville M.D.'s Harold W. Bradshaw, H. William Fister, Hoyt D. Gardner, Harvey C. Hardegree, Jr., Daniel E. Mahaffey, Frederick C. Reiss and Giles L. Stephens. Others in the Kentucky list are Edward C. Bowling, Jr., M.D., Lebanon; Caleb H. Y. Chu, M.D., Oneida; Crocker B. Clegg, M.D., Elizabethtown; William G. Clouse, M.D., Richmond; Royce E. Dawson, M.D., Owensboro; Edwin L. Jones, M.D., Mount Sterling; Glenn Louis Pfister, M.D., Fort Thomas; Reginald J. Phillips, Jr., M.D., Owensboro; Ray M. Slabaugh, M.D., Lexington; Richard C. Stuntz, M.D., Harlan, and John F. Weiksnar, M.D., Whitesburg.

Dr. Lackey Scholarship Established

A $2,000 scholarship fund, to be used by a Trigg County boy to finish his medical education at the University of Kentucky Medical Center, has been set up by the Rev. Tom Lackey, pastor of Johnson's Methodist Church, Nashville. It will be called the "Dr. James Henry Lackey Scholarship" in memory of his father.

Doctor Lackey, who was born in Trigg County and practiced medicine at Canton for half a century, presented the first bill in the Kentucky Legislature that advocated establishment of a medical school for the University of Kentucky. He served two terms in the State Legislature. His minister son is writing a book, "River Town Doctor," based on Doctor Lackey's life in the Canton community.

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The consistent relief of emotional tensions afforded by Dartal makes this well-tolerated tranquilizer a rational choice to support the antispasmodic action of Pro-Banthīne in emotionally influenced smooth-muscle spasm.

These two reliable agents combined as Pro-Banthīne with Dartal consistently control both disturbed mood and disordered motility when emotional disturbances project themselves through the vagus to provoke such gastrointestinal dysfunctions as gastritis, pylorospasm, peptic ulcer, spastic colon or biliary dyskinesia.

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Was Your Delegate Present?

ROLL CALL—1960 House of Delegates*
KSMA Annual Meeting

	OFFICERS	First Session	Second Session
Speaker	Sam A. Overstreet	Present	Present
Vice Speaker	Garnett J. Sweeney	. . . .	. . . .
President	Irvin Abell, Jr.	Present	Present
President-Elect	Richard G. Elliott	Present	Present
Vice-President	David M. Cox	Present	Present
Vice-President	William O. Preston	Present	Present
Vice-President	Rex E. Hayes	Present	. . . .
Secretary	W. B. Troutman	Present	Present
Treasurer	Delmas M. Clardy	Present	Present
Delegate to the AMA	W. Vinson Pierce	Present	Present
Delegate to the AMA	Robert C. Long	Present	Present
Alternate Delegate to the AMA	J. Vernon Pace	Present	Present
Alternate Delegate to the AMA	George P. Archer	Present	Present

	TRUSTEES		
District			
First	Hugh L. Houston	Present	Present
Second	Walter L. O'Nan	Present	Present
Third	Ralph D. Lynn	Present	. . . .
Fourth	Dixie E. Snider	. . . .	Present
Fifth	Carlisle Morse	Present	Present
Sixth	John P. Glenn	Present	Present
Seventh	Wyatt Norvell	Present	Present
Eighth	Norman Adair	Present	Present
Ninth	J. M. Stevenson	Present	Present
Tenth	Douglas E. Scott	Present	Present
Eleventh	Joe M. Bush	Present	Present
Twelfth	Thomas O. Meredith	Present	Present
Thirteenth	Charles B. Johnson	Present	Present
Fourteenth	William C. Hambley	. . . .	Present
Fifteenth	Keith P. Smith	Present	Present

	PAST PRESIDENTS		
1958	R. W. Robertson	Present	Present
1957	Edward B. Mersch	. . . .	. . . .
1956	Richard R. Slucher	. . . .	Present
1955	J. Gant Gaither	. . . .	. . . .
1954	Clyde C. Sparks	. . . .	Present

DELEGATES

First District

County		First Session	Second Session
BALLARD	Jesse M. Hunt	. . . .	. . . .
CALLOWAY	A. D. Butterworth	Present	Present
CARLISLE	John T. O'Neill	. . . .	. . . .
FULTON	R. Ward Bushart	. . . .	. . . .
GRAVES	Richard Colley	. . . .	. . . .
HICKMAN	V. A. Jackson	. . . .	. . . .
LIVINGSTON	Roscoe Faulkner	. . . .	. . . .
McCRACKEN	Walter Johnson	Present	Present
	R. M. Wooldridge	Present	Present
	Leon Higdon	Present	Present
MARSHALL	Joe Miller	. . . .	Present

Second District

DAVIESS	L. P. Moore	Present	. . . .
HANCOCK			
HENDERSON	Kenneth Eblen	Present	Present
McLEAN	E. S. Coleman	. . . .	. . . .
OHIO	Oscar Allen	Present	Present
UNION			
WEBSTER			

Third District

CALDWELL	Frank Giannini	. . . .	Present
CHRISTIAN	Harvey B. Stone	Present	Present
CRITTENDEN	R. M. Brandon	. . . .	. . . .
HOPKINS	Loman C. Trover	Present	Present
	F. A. Scott	Present	Present
LYON	Joe E. Cotthoff	Present	Present
MUHLENBERG	G. L. Simpson	Present	. . . .
	George Brockman (Alternate)	. . . .	Present
TODD	J. C. Woodall	Present	Present
TRIGG	Elias N. Futrell	Present	. . . .

Fourth District

BRECKINRIDGE	W. R. Morris	. . . .	. . . .
BULLITT	Bruce Hamilton	Present	. . . .
GRAYSON	P. A. O'Neill	. . . .	. . . .
GREEN	Robert Shuffett	. . . .	. . . .
HARDIN	R. T. Routt	Present	Present
	Leo C. McCampbell	. . . .	. . . .
HART	David R. Upton	Present	Present
LARUE	J. D. Handley	. . . .	Present
MARION	B. J. Baute	Present	Present
MEADE	George C. Clark	. . . .	. . . .
NELSON	J. J. Sonne	Present	. . . .
SPENCER	William K. Skaggs	Present	. . . .
TAYLOR	H. F. Chambers	Present	. . . .
WASHINGTON	Harold B. Simms	Present	Present

Fifth District

JEFFERSON	Benjamin D. Boone	Present	Present
	J. Randolph Buskirk	. . . .	Present
	Rudy J. Ellis	Present	Present
	Thomas V. Gudex	Present	Present
	Robert L. McClendon	Present	Present
	Alfred O. Miller	Present	Present
	F. Albert Olash	Present	Present
	William E. Oldham	Present	Present
	Rudolph F. Vogt	. . . .	. . . .
	Everett H. Baker	Present	Present
	William Buschemeyer	Present	Present
	Kenneth P. Crawford	Present	Present
	George B. Kimbrough	. . . .	Present
	Nathan I. Handelman	Present	Present
	Daniel E. Mahaffey	Present	. . . .
	J. Robert Flautt	. . . .	Present
	Stanley E. Smith	Present	Present
	Robert S. Tillett	Present	Present
	Austin Bloch	Present	Present
	Charles J. Bisig	Present	Present
	Harold Eskind	Present	. . . .
	David W. Kinnaird	Present	Present
	Paul Mapother	Present	Present
	Harry A. Pfingst	. . . .	. . . .
	George A. Sehlinger	. . . .	Present
	David H. Thurman	Present	Present
	Robert L. Woodard, Jr.	Present	Present

Sixth District

ADAIR	M. C. Loy	Present	. . . .
ALLEN	John W. Meredith	. . . .	Present
BARREN	W. H. Bryant	Present	Present
BUTLER	D. G. Miller, Jr.	Present	Present
CUMBERLAND	Joseph Schickle	. . . .	. . . .
EDMONSON			
LOGAN	C. V. Dodson	Present	Present
METCALFE	P. D. Hitchcock	. . . .	. . . .
MONROE	William R. Bushong	Present	Present
SIMPSON	L. F. Beasley	Present	Present
WARREN	Harold Keen	Present	Present
	Harper Wright	. . . .	. . . .

Seventh District

ANDERSON	Lewis Wash	Present	Present
CARROLL	Carl H. Boylen	. . . .	. . . .
FRANKLIN	John B. Clay	. . . .	Present
GALLATIN	G. F. Harris	Present	Present
GRANT	Claude C. Waldrop	Present	Present
HENRY	R. L. Houston, Jr.	Present	Present
OLDHAM	Burl Mack	Present	Present
OWEN	O. A. Cull	. . . .	. . . .
SHELBY	Robert Hamm	Present	Present
TRIMBLE	Carl Cooper	. . . .	Present

Eighth District

BOONE	Joseph F. Daugherty	Present	Present
CAMPBELL-KENTON	Richard Rust	. . . .	Present
	J. J. Rolf	Present	Present
	W. R. Houston	Present	. . . .
	D. H. Frickman	. . . .	. . . .
	Carl Kumpe (Alternate)	. . . .	. . . .
	W. T. McElhinney	. . . .	Present
	J. H. Humpert	. . . .	. . . .

Ninth District

BATH	Robin A. Byron	. . . .	. . . .
BOURBON	Richard J. Wever	. . . .	Present
BRACKEN	Carl A. Marquardt	. . . .	. . . .
FLEMING	R. W. Fidler	. . . .	. . . .
HARRISON	J. P. Wyles	. . . .	. . . .
MASON	Claude E. Cummins	Present	. . . .
NICHOLAS	B. F. Reynolds	. . . .	. . . .
PENDLETON	William M. Townsend	. . . .	. . . .
ROBERTSON	Perry Overby	. . . .	. . . .
SCOTT	C. R. Lewis	. . . .	Present

Tenth District

FAYETTE	M. C. Darnell	Present	Present
	N. L. Bosworth	Present	Present
	Robert B. Warfield	Present	Present
	Robert D. Shepard	Present	Present
	Carl H. Fortune	Present	Present
	Maurice Kaufmann	Present	Present
	E. C. Strode	Present	Present
	R. M. Slabaugh	Present	Present
	J. H. Saunders	Present	. . . .
JESSAMINE	J. S. Williams	Present	. . . .
WOODFORD	George Reed	. . . .	Present

Was Your Delegate Present?

ROLL CALL—1960 House of Delegates*

		First Session	Second Session
	Eleventh District		
CLARK	Thomas Averitt	Present	. . . .
ESTILL	S. G. Marcum	. . . .	. . . .
JACKSON			
LEE	J. M. Smith	. . . .	Present
MADISON	Douglas Jenkins	Present	Present
	Hubert C. Jones	Present	Present
MENIFEE	D. L. Graves	. . . .	. . . .
MONTGOMERY	W. H. McKenna	Present	. . . .
OWSLEY	M. B. Gabbard	. . . .	. . . .
POWELL	S. T. Scrivner	. . . .	. . . .
WOLFE	Paul F. Maddox	. . . .	. . . .
	Twelfth District		
BOYLE	Chris Jackson	. . . .	. . . .
CASEY	Lewis Wesley	. . . .	. . . .
CLINTON	Ernest A. Barnes	. . . .	. . . .
GARRARD	O. S. Playforth	Present	Present
LINCOLN	H. I. Frisbie	Present	Present
McCREARY	M. A. Winchester	. . . .	. . . .
MERCER	Bacon Moore	Present	. . . .
	E. H. John	. . . .	Present
PULASKI	B. L. Ramsey	Present	Present
ROCKCASTLE	George H. Griffith	. . . .	. . . .
RUSSELL	Charles E. Peck	. . . .	. . . .
WAYNE	John W. Simmons	Present	Present
	Thirteenth District		
BOYD	Guy C. Cunningham	Present	Present
	Paul E. Holbrook	Present	Present
CARTER	J. Watts Stovall	Present	Present
ELLIOTT	John F. Greene	. . . .	. . . .
GREENUP	C. I. Haeberle	Present	. . . .
LAWRENCE	Forest F. Shely	Present	. . . .
LEWIS			
MORGAN	Hershell Murray	Present	. . . .
ROWAN			
	Fourteenth District		
BREATHITT	Robert E. Cornett	. . . .	. . . .
FLOYD	Russell L. Hall	Present	Present
JOHNSON	James W. Archer	Present	Present
KNOTT	Denzil Barker	. . . .	Present
LETCHER	T. M. Perry	. . . .	Present
MAGOFFIN			
MARTIN			
PERRY	C. D. Snyder	Present	. . . .
PIKE	John H. Scott, Jr.	Present	Present
	Fifteenth District		
BELL	David C. Asher	Present	. . . .
CLAY	W. E. Becknell	Present	. . . .
HARLAN	David M. Greeley	Present	Present
	E. M. Howard	Present	Present
KNOX	T. R. Davies	Present	. . . .
LAUREL	R. E. Pennington	Present	Present
LESLIE			
WHITLEY	W. R. Buttermore	Present	Present
TOTAL		121	119

** The information in the roll call was taken from the attendance record cards signed by the delegates prior to the meetings on September 19 and 21.*

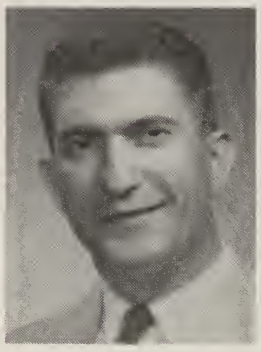
Behavioral Sciences Unit Set Up

A Division of Behavioral Sciences has been established in the State Department of Health, with the appointment of Raymond Forer, Ph.D., as director and Seymour Warkov, Ph.D., as head of research activities. Doctor Forer has been active as a research scientist with a number of public health agencies in Connecticut. Doctor Warkov comes from a research position at Lankenau Hospital, Philadelphia.

Russell E. Teague, M.D., State Commissioner of Health, said the new program will attempt to investigate and evaluate the relationship between the needs of the individual and those cultural and social patterns which affect preventive measures as well as the medical and clinical care of patients. The division will work closely with the University of Kentucky Medical Center, he said.

Arvil McKinney Is Promoted By Blue Cross - Blue Shield

Blue Cross-Blue Shield has announced the appointment of Arvil McKinney as director of Hospitals-Physicians Service Department for the state of Kentucky. He will also continue his present duties as special representative in the Louisville area.



Mr. McKinney

Mr. McKinney has been with Blue Cross-Blue Shield since 1953, and has been in the Hospitals - Physicians Service Department since 1957.

A native of Pineville, he was formerly district director of enrollment for that area. He is a past president of the Kentucky State Junior Chamber of Commerce. During World War II he served with the U.S. Air Corps in Korea.

1,200 Insuring Groups Provide Americans Health Coverage

Americans were getting health coverage from 1,200 insuring organizations at the close of 1959, the Health Insurance Institute of New York City reported on October 3. The groups included 737 insurance companies, 78 Blue Cross and 68 Blue Shield plans, and over 300 other plans.

A total of 127,896,000 persons had health insurance, and some $5.2 billion in health-insurance benefits was distributed during 1959, the Institute said.

A check of a seven-year period revealed that from 1952 to 1959 there was a 43 per cent increase in the over-all number of insurance companies writing health insurance. The number of life insurance companies engaged in the health insurance field rose from 284 to 490 in the period, an increase of 73 per cent.

Most health insurance coverage is provided by group plans protecting a large number of persons under one policy, such as at places of employment, the Institute reported. Of the 128 million Americans with hospital expense insurance at the end of 1959, insurance companies covered a net total of 75 million persons, including 51 million protected under group policies.

M.D.'s Give Hospital $22,200

Medical donors have given a total of $26,422.07 toward a new wing at the Hopkins County Hospital, Madisonville, the building fund committee has reported. Physicians contributed $22,200 of the amount, with the balance given by hospital employees, the Medical Auxiliary, dentists, clinic employees and pharmacies.

A total of $150,000 in public donations is being sought in the hospital-expression program.

KAGP Hopkinsville Seminar Planned For Nov. 10

The program for the Hopkinsville Seminar of the Kentucky Academy of General Practice, set for November 10, has been announced by Preston T. Higgins, M.D., Hopkinsville, chairman. Registration will start at 1 p.m. at the Hopkinsville Golf and Country Club.

Four speakers are scheduled for the scientific session. Robert Lich, Jr., M.D., Louisville, will talk on "Urodiagnosis"; Will W. Ward, Jr., M.D., Louisville, will present a paper on "Practical Application Of Pancreatic Function Tests"; James A. Calloway, M.D., Nashville, will speak on "Practical Application Of Pulmonary Function Tests," and Thomas K. Helper, M.D., Clarksville, Tenn., will discuss "Practical Application Of Liver Function Tests."

C. Maxwell Lancaster, professor of romances languages at Vanderbilt University, Nashville, will be the dinner speaker. His topic will be "Words In the World Today."

A special program, including a luncheon and fashion show, has been planned for wives at the Skyline Country Club.

The seminar has been accepted for 4 hours of Category I Credit. No registration fee will be charged.

KAGP Holds Maysville Seminar

The Kentucky Academy of General Practice held its Maysville Seminar at the Mason County Health Department Building, Maysville, on October 28. Essayists scheduled for the scientific presentation were Arthur A. King, M.D., and Thomas Asbury, M.D., of the University of Cincinnati; Penn G. Skillern, M.D., of the Cleveland Clinic, and Hugh B. Lynn, M.D., of the University of Louisville School of Medicine. Clayton Scroggins, Cincinnati, was the evening speaker.

George E. Estill, M.D., Maysville, was chairman of the program.

Kenlake Seminar Draws 45

Forty-five physicians attended the seventh annual Kenlake Seminar presented October 6 by the Kentucky and Tennessee Chapters of the American Academy of General Practice. The meeting was held at Kenlake Hotel, Hardin.

Essayists were Lawrence Goldberg, M.D., University of Cincinnati School of Medicine; Oren Depp, M.D., Tulane University, New Orleans; Addison B. Scoville, M.D., Vanderbilt University School of Medicine, Nashville, and Leslie W. Blakey, M.D., Lexington Clinic, Lexington.

Seek City Water Fluoridation

A delegation of Madisonville physicians and dentists recently appeared before the City Council to request fluoridation of the city's water supply. Spokesman for the group was E. R. Gernert, M.D., associate director of the Division of Dental Health of the State Department of Health.

Health Building To Be Enlarged

Plans to enlarge the new State Department of Health building in Frankfort, at an estimated cost of $400,000, were announced last month. Finance Commissioner Robert F. Matthews, Jr., said construction is expected to begin early next year and probably be completed by the following September.

The program calls for the addition of first and second floor bays to the three back wings of the building, increasing the floor space by about 30,000 square feet, or 25 per cent. The present structure, which was occupied by the Health Department last spring, cost $2,918,000.

Mental-Health Consultant Named

The State Department of Health has announced the appointment of a consultant public-health nurse for the evaluation center at Children's Center for mentally retarded children in Louisville. Named to the post was Mrs. Mary Sergent, a graduate of Norton Memorial Infirmary School of Nursing, Louisville, who received mental-health training at Indiana University. She has been a supervisor in a Missouri state mental institution. The center, opened eight months ago, is under the direction of Martin Z. Kaplan, M.D.

U.K. Scientist Gets $20,700 Grant

Dr. Ralph F. Wiseman, associate professor of bacteriology at the University of Kentucky, has received a grant of $20,700 from the National Institute of Arthritis and Metabolic Diseases. The three-year grant is for study of uric acid found in large quantities in the blood streams of victims of gout and arthritis. Dr. Wiseman will seek to find the relationship between uric acid in the intestinal tract and the disease conditions often associated with high levels of the acid in the blood.

Allergy Course Set At Hardin

A comprehensive course in allergy is planned for December 5-9, inclusive, at the Kenlake Hotel, Hardin, by Herbert J. Rinkel, M.D., and Z. Z. Godlowski, M.D. Persons interested in the course are asked to contact William C. Wolfe, M.D., in Louisville.

Ophthalmology Course In Ohio

"Newer Developments In Ophthalmology" is the subject of a postgraduate course scheduled for December 7-8 by the Frank E. Bunts Educational Institute, Cleveland. The program will be presented in the North Clinic Building by staff members of the Cleveland Clinic Foundation, assisted by several guest speakers. As registration is limited to 125, reservations should be made in advance, advises Charles L. Leedham, M.D., director of education. The institute's address is: 2020 East 93rd Street, Cleveland 6, Ohio.

"Trends In Medicine" was the topic of a discussion by **Carroll Witten, M.D.**, Louisville, before the Student AMA in Chicago on October 8.

NEWS ITEMS

John M. Allen, M.D., former Jackson physician, has moved to Lexington to join **David A. Hull, M.D.**, in the practice of general surgery.

William O. Allen, M.D., Pikeville, was chairman of the Girl Scout fund drive in Pikeville, September 22-October 12.

John Russell Cole, M.D., has joined the staff of the Lexington Clinic, Lexington, specializing in urology. A native of Winchester, he received his M.D. degree from Yale University in 1954. He interned at Strong Memorial Hospital, Rochester, N. Y., where he also served a residency in general surgery, 1955-57, and in urology, 1957-60.

John S. Collis, Jr., M.D., Winchester, won the resident essay contest sponsored by the Ohio Chapter, American College of Surgeons, at its annual meeting in Akron, Ohio. His paper was titled "Autopsy Permission." A graduate of the University of Louisville School of Medicine, Doctor Scott is completing his neurosurgery residency at the Cleveland Clinic Foundation.

Clyde R. Danks, M.D., who practiced in Vine Grove and Radcliff from August 1958 to June 1960, has moved to Galveston, Texas, where he is taking specialty training in radiology. A native of McHenry, Doctor Danks received his M.D. degree from the Unversity of Louisville School of Medicine in 1955, interned at University of Oklahoma hospitals, and took residency training at University of Texas medical branch hospitals in Galveston. He served two years in the U. S. Navy with the rank of lieutenant.

Sidney P. Edds, M.D., Burnside, has accepted a two-year residency in anesthesiology at the John Gaston Memorial Hospital, Memphis, Tenn., beginning January 1. The hospital is affiliated with the University of Tennessee School of Medicine.

John L. Jenkins, M.D., pediatrician, has started practice in Henderson after a two-year residency at Children's Hospital, Louisville. Born in Sebree, Doctor Jenkins received his M.D. degree from the University of Louisville School of Medicine in 1957 and served his internship at Henry Ford Hospital, Detroit.

Gerald H. McCord, M.D., and **Ferris I. Larsen, M.D.**, have opened an office in Earlington in association with the Trover Clinic in Madisonville. Doctor McCord, who was born in Murray, was graduated from the University of Louisville School of Medicine in 1959 and interned at Kentucky Baptist Hospital, Louisville. Doctor Larsen, a native of Gowen, Mich., received his medical degree from Wayne University, Detroit, in 1957 and took his internship at Butterworth Hospital, Grand Rapids, Mich. He served in the U. S. Public Health Service from 1958 to 1960.

Walter R. Morris, M.D., has notified the Journal of the change of his address from Cloverport to Philadelphia, where he will engage in a residency training program.

E. F. Puess, M.D., has resigned as medical director of District 6, State Tuberculosis Hospital, Glasgow, to join his aged mother in Chicago. A testimonial dinner in honor of Doctor Puess and Mrs. Puess was given at the hospital on September 12.

James S. Rieser, M.D., has opened an office in the Owens Medical Center, 4122 Shelbyville Road, Louisville, for the general practice of medicine. A native of New York City, Doctor Rieser was graduated from the University of Louisville School of Medicine in 1959 and interned at Louisville General Hospital. He served in the Army Air Corps for three and a half years, 1943-1946.

Fred R. Scroggins, M.D., Williamstown, has been appointed to the Kentucky Fish & Wildlife Resources Commission to represent the Fifth Kentucky Wildlife District. Doctor Scroggins was elected the 1959 Kentucky Sportsman of the Year. He is the immediate past president of the League of Kentucky Sportsmen and is a former president of the Fifth District Federation of Kentucky Sportsmen.

B. Pressley Smith, M.D., who has been located at Hawesville since 1954, has extended his practice to Cloverport in association with E. Hart, M.D. Born in China, Doctor Smith was graduated from the University of Louisville School of Medicine in 1953 and interned at Louisville General Hospital. He served in the U. S. Navy from 1943 to 1946.

Will W. Ward, Jr. M.D., has started the pratcice of internal medicine in Louisville in associaton with **Doctors Hendon, Blodgett, Minish and Graves.** He previously practiced at the U.S.A.F. Hospital, Dhahran-Saudia, Arabia, and the U.S.A.F. Hospital, Selfridge A.F.B., Michigan. A native of Frankfort, Doctor Ward earned his M.D. degree from the University of Louisville School of Medicine in 1954, interned at the hospital of the University of Pennsylvania and took residency training at the University of Michigan. He served two years in the U. S. Air Force with the rank of captain.

Margaret Bolton Vermillion, M.D., has opened an office in Middletown, specializing in pediatrics and pediatric cardiology. A member of the staff of the Department of Pediatrics, University of Louisville School of Medicine, the past three years, Doctor Vermillion has also been assistant medical director of the Kentucky Children's Heart Clinic and consultant in pediatric cardiology to the State Department of Health since 1957. Born in Hazard, she received her medical degree from Tulane University in 1952, followed by a rotating internship and a pediatric residency at the Crawford W. Long Memorial Hospital of Emory University, Atlanta. Her postgraduate training also includes: Pediatric residencies at General Hospital and Children's Hospital, Louisville; U. S. PH traineeship and research fellowship in pediatric cardiology at U. of L. School of Medicine.

Postgraduate Opportunities Listed For Three-Month Period

Postgraduate medical opportunities in Kentucky and adjoining states for the next three-month period are announced by the Postgraduate Medical Education Office.

Detailed information on the listings may be obtained by contacting the office at 104 West Chestnut Street, Lousville 2. The telephone number is Juniper 7-7135.

The complete listing follows:

November

15 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

16-18 Postgraduate course, "Electrocardiography"; University of Buffalo School of Medicine, Buffalo 14, N. Y.

17 Postgraduate course, "Neurology and Psychiatry in General Practice," University of Nebraska, College of Medicine, Omaha.

17 State TB Hospital, District Five, seminar; London, Ky.; registration at 2:30 p.m.

17 "Cardiac Day," one-day symposium; Vanderbilt University School of Journalism. Nashville 5, Tenn.

17-19 Postgraduate course, "Orthopedic Surgery"; University of Texas Southwestern Medical School, Dallas.

December

9-10 Postgraduate course, "Neurology"; University of Texas Southwestern Medical School, Dallas.

15 John N. Norton Memorial Infirmary Medical Seminar; postgraduate course at the Infirmary in Louisville.

20 State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

December through January—Tentative intermittent course (12 weeks, one-half day each week) on EKG Interpretation; Louisville General Hospital.

January

6 Postgraduate course, "Ophthalmology"; University of Texas Southwestern Medical School, Dallas.

19-20 Postgraduate course, "Obstetrics & Gynecology"; University of Nebraska College of Medicine, Omaha.

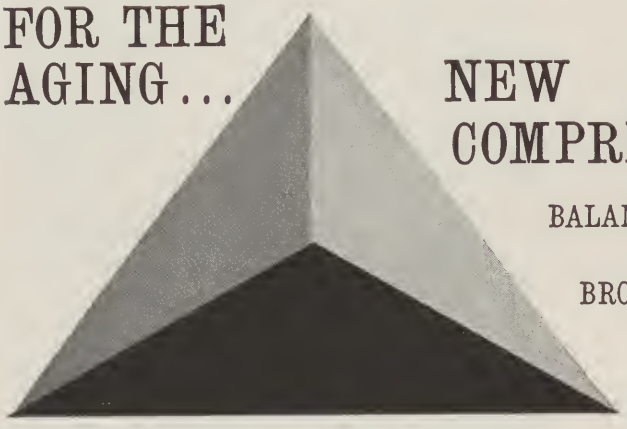
25-27 Postgraduate course, "Clinical Hematology"; University of Tennessee College of Medicine, Memphis 3.

February

6-7 Postgraduate course, "Electrocardiology"; Course I, University of Nebraska College of Medicine, Omaha 5.

6-7 Annual Surgical Meeting (Tentative); Dr. M. Stanley, Louisville.

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Student AMA

I am sure that all of us have the memory or knowledge of some particular individual for whom we hold a great deal of respect and in whom we place a great deal of trust. He may be a teacher, minister, physician or just the next-door neighbor, but he is set apart from those about him by the alertness of his spirit, the steadfast way he holds to his convictions and the unrelenting respect which he commands from those about him. A closer look at him will most likely reveal that the attitude of respect he enjoys personally he also holds for others and in so doing brings out the best that is in them. That which is expected of him he demands and obtains from others.

The M.D. is very often such a person as this and the history of his profession has been colored by a deep and genuine respect which people have placed in his ability, his personality and his individuality. The ideals represented by medicine are characterized by this individual. The faith placed in his ability to prevent or alleviate pain, sickness, and even death is preserved and a classic sense of professional, ethical rapport is established between medicine and its patients.

Unfortunately, and all too often, as in all other professions, such is not the case. Professional rapport does not exist. Faith in the doctor's ability fails and disillusionment and disappointment not only for the patient but for the physician as well is the result. The doctor has failed to gain and has failed to give the respect which he needs in order to make a more successful life and a more successful profession.

Medical students, particularly during their clinical training, are faced with the first real challenge in demanding and giving respect as it is directly related to their future work. The manner in which they approach their patients, the association with the resident and teaching staff of the hospital, the laboratory personnel and, most surely, the nursing staff will begin to indicate the overall respect which they will command.

If the student's approach is sincere and honest, if it is honorable and endowed with character, then these qualities will be his for all time as well as gain for him respect in his present situation. On the other hand, if he is negligent, weak, lacking in basic moral and ethical principles and uninterested in developing and maturing his professional manner, then not only will he fail to gain respect from his fellow students and the hospital staff today but, more important, will lack the respect of his patients in his future practice.

It would seem, then, that a respected physician is one who has disciplined himself to command as well as give respect and that much of this discipline results from his attitude and training while still a student.

Olson Huff, Vice-President
University of Louisville Chapter
Student AMA

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Floyd County

Russell L. Hall, M.D., was elected secretary-treasurer of the Floyd County Medical Society at the September meeting at Our Lady of the Way Hospital, Martin. He succeeds John G. Archer, M.D., who resigned.

On the motion of George P. Archer, M.D., president, the society admitted Norman E. White, M.D., as an associate member. He will be eligible for full membership in a year.

A three-man committee was appointed to assist in carrying out certain provisions of the recently-enacted Indigent Medical Care Law. Named were Doctor Hall, chairman; Doctor White and Claude Allen, M.D.

The program also included a discussion on the acute shortage of physicians in the area, with suggestions on how to remedy the situation.

The final item of business was the unanimous adoption of a resolution relating to licensing of physicians.

McCracken County

Establishment of a County Review Committee for Indigent Medical Care was one of the subjects presented to the McCracken County Medical Society at its September meeting. Correspondence from the Executive Committe of the KSMA Council was read and discussed. It was decided to make up a list of nine local physicians, from which three will be selected.

Examination of school teachers applying for retirement disability also came up for discussion. Since there are so few general practitioners in the society, the suggestion was made that the secretary write for further information regarding the examination to pass on to interested physicians.

The society voted unanimously to accept William D. Shidal, M.D., as an active member. He transferred from the Hardin County Society.

Crawford W. Adams, M.D., Nashville, presented the scientific program, titled "Renal Hypertension—Evaluation by Rentrograde Aortography."

Nutrition Symposium Set Nov. 30

Outstanding authorities in the field of nutrition will be featured in a symposium on clinical nutrition scheduled for November 30 in Washington, D. C. Sponsored by the Council on Foods and Nutrition of the American Medical Association in cooperation with the Medical Society of the District Columbia, the program will begin at 8:30 a. m. in Room B of the National Guard Armory. The meeting is open to all interested persons.

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In Memoriam

J. H. KINCHELOE, M.D.
Hardinsburg
1913 - 1960

John Allen Kincheloe, M.D., Hardinsburg, died on October 7 at Kentucky Baptist Hospital, Louisville. He was 47.

Doctor Kincheloe was the third generation of a family of physicians that served Breckinridge county 90 years. He was a 1943 graduate of the Kansas City University of Physicians and Surgeons.

R. D. SPARKS, M.D.
West Liberty
1871-1960

R. D. Sparks, M.D., retired physician of West Liberty, died August 28 in a hospital there after an illness of three years. He had practiced 64 years, during which time he delivered 5,009 babies.

A native of Martha, Ky., Doctor Sparks received his M.D. degree from the Louisville Medical College in 1893 and started the practice of medicine in Elkfolk. From there he moved to West Liberty, where he practiced for more than 60 years.

EDWARD J. TRACY, M.D.
Louisville
1897-1960

Edward J. Tracy, M.D., retired Louisville physician who had been a medical examiner for the Selective Service the past 10 years, died October 13 at St. Joseph Infirmary, Louisville, after a two-week illness. Doctor Tracy did not resume practice after serving three years as an Army doctor during World War II.

A native of Jeffersonville, Doctor Tracy received his medical degree from the University of Louisville School of Medicine in 1919. He interned at Dayton, Ohio.

HERMAN MAHAFFEY, M.D.
Louisville
1897-1960

A heart attack suffered October 13 was fatal to Herman Mahaffey, M.D., Louisville physician the past 30 years. He was stricken while fishing in a pond near LaGrange.

A 1921 graduate of the University of Louisville School of Medicine, Doctor Mahaffey opened an office in Louisville in 1930 for the general practice of medicine. In 1937, after a year's study in Vienna, he started practicing as a surgeon. Doctor Mahaffey was a member of a physician family. His father, John A. Mahaffey, M.D., was a Richmond surgeon until his death six years ago. His two sons, J. Herman Mahaffey, M.D., and Daniel E. Mahaffey, M.D., are Louisville physicians, and his brother, Hugh Mahaffey, M.D., is a Richmond surgeon.

ASA C. OVERALL, M.D.
Lawrenceburg
1882 - 1960

Asa Caperton Overall, M.D., Lawrenceburg physician since 1913, died unexpectedly at his home September 29 of a cerebral hemorrhage. He was 79.

A native of Nelson county, Doctor Overall was graduated from the old Louisville Medical College in 1904. He practiced in Mount Washington before moving to Lawrenceburg.

T. P. SCOTT, M.D.
Carlisle
1878-1960

Thompson Parks Scott, M.D., retired Carlisle physician, died October 13 at a Winchester nursing home. He was 82.

Born in Jeffersonville, Ill., Doctor Scott was graduated from the University of Cincinnati College of Medicine and practiced in Kansas before moving to Kentucky in 1918. Upon completion of 50 years of practice in 1955, he was honored by Carlisle civic organizations.

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Pertinent Paragraphs

The American College of Chest Physicians will hold its annual interim session at the Shoreham Hotel in Washington, D. C., on Saturday and Sunday, November 26 ad 27. Administrative sessions are scheduled for Monday, November 28. The scientific program will include symposia on congenital bronchopulmonary disorders, the role of steroid therapy in chest diseases, and current therapeutic issues.

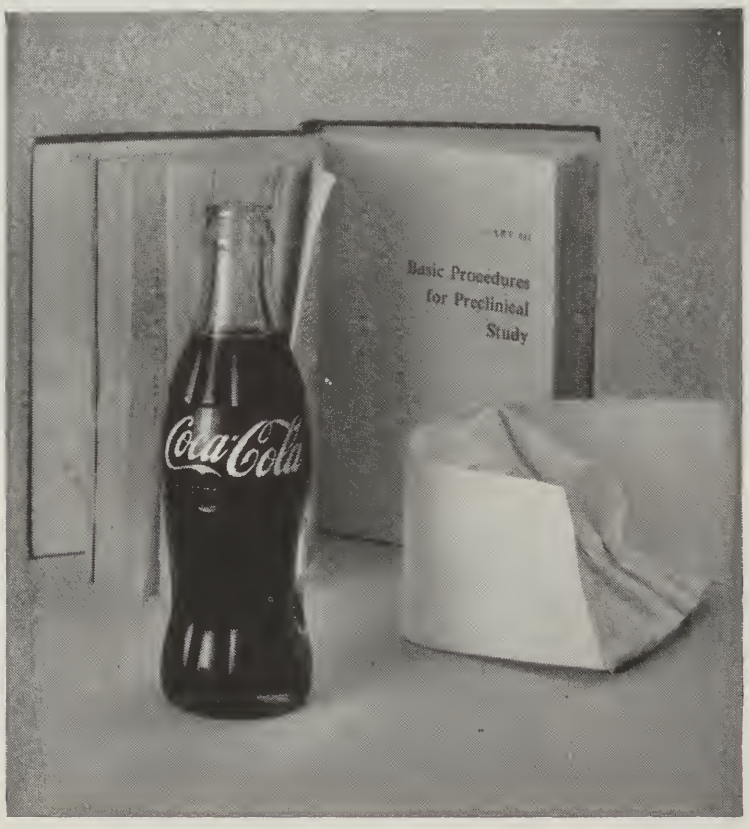
"Changing Concepts in Tumor Formation and Therapy" is announced as the theme of the ninth annual Cancer Seminar of the Arizona Division, American Cancer Society, set for January 12-14 at the Tidelands Motor Inn, Tucson. The meeting will be devoted to various aspects of chemotherapy, virology, endocrinology and environmental factors as they relate to tumor formation or the therapy of tumors. Darwin W. Neubauer, M.D., editor of *Arizona Medicine,* is chairman of the program.

"Problems of the Newborn Infant" is the subject of a postgraduate course to be presented by the Medical College of Georgia and Foundation in Augusta, January 24-26. The course will focus attention on the ill newborn infant. Registration fee is $50 per course. Applications should be sent to Claude-Starr Wright, M.D., professor of medicine and director, Department of Continuing Education, Medical College of Georgia, Augusta, Ga.

The Rocky Mountain Traumatic Surgical Society, in announcing its January 26-28 meeting at Aspen, Colo., urges the importance of making reservations as soon as possible. Guest speakers, according to the preliminary program, will include John A. Schilling, M.D., and Robert M. Bird, M.D., of the University of Oklahoma Medical Center, and William Convode, M.D., and Dale Atkins, M.D., Denver urologists. Headquarters will be at the Aspen Meadows.

The International Medical Assembly of Southwest Texas has announced January 23-25 as the date of its 25th annual session to be held at the Granada Hotel, San Antonio. Seventeen speakers are scheduled for scientific presentations. Additional information may be obtained by writing to Max E. Johnson, M.D., president, or S. E. Cockrell, Jr., executive secretary, 202 West French Place, San Antonio 12, Texas.

The Van Meter Prize Award of $300 is again being offered by the American Goiter Association to the essayist submitting the best manuscript of original and unpublished work concerning "Goiter—especially its basic cause." The award will be made at the association's annual meeting in Philadelphia, May 3-6, 1961. Competing essays may cover either clinical or research investigations and should not exceed 3,000 words. They should be sent to the secretary, John C. McClintock, M.D., 702 Madison Avenue, Albany 8, N. Y., not later than January 1.



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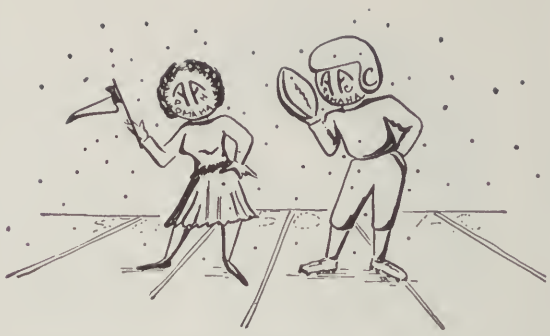
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Hollander[1] points out the superiority of triamcinolone in not causing mental stimulation, increased appetite and weight gain, compared to other steroids which produce these effects in varying degrees. And McGavack,[2] in a comparative tabulation of steroid side effects, indicates that triamcinolone does not produce the increased appetite, insomnia, and psychic disturbances associated with other newer steroids.

ARISTOCORT can thus be advantageous for patients requiring corticosteroids whose appetites should not be stimulated, and for those who are already overweight or should not gain weight. Likewise, ARISTOCORT is suitable for the many patients with emotional and nervous disorders who should not be subjected to psychic stimulation. Furthermore, ARISTOCORT Triamcinolone, in effective doses, showed a low incidence of side reactions and is a steroid of choice for treating the older patient in whom salt and water retention may cause serious damage.[2]

References: 1. Hollander, J. L.: *J.A.M.A.* 172:306 (Jan. 23) 1960. 2. McGavack, T. H.: *Nebraska M. J.* 44:377 (Aug.) 1959. 3. McGavack, T. H.; Kao, K. Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958.

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. Dosage should be individualized and kept at the lowest level needed to control symptoms. It should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

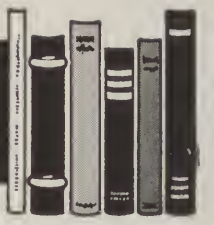
Supplied: Scored tablets—1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white).

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IN THE BOOKS



YOUR HEART—A HANDBOOK FOR LAYMEN: by H. M. Marvin, M. D.; published by Doubleday & Company, Inc., Garden City, N.Y.; 335 pages; price, $4.50.

Any effort intended to bring comfort to heart patients is worthwhile. Millions of our countrymen suffer from heart disease in some form. A patient who understands his difficulty usually is less afraid and makes a much better adjustment to his trouble.

Dr. Marvin is a past president of the American Heart Association and his discussion gives proof of his complete familiarity with problems and solutions to problems related to heart disease. The author discusses theories as well as standard practices in the management of cardiac disease. Misconceptions are also dealt with in a most satisfactory manner.

The reviewer recommends this book to all physicians who manage heart patients. It is possible this work serves its greatest need in this group. Not all patients are mentally competent to assimilate the many details presented. Others are not sufficiently stable emotionally to gain benefits from this discussion. A good doctor-patient relationship during convalescence is most important and many hints on achieving this are presented. This book is recommended for all of us who treat heart disease, as well as selected patients.

Frank H. Moore, M. D.

WOMEN AND FATIGUE: by Marion Hilliard, M.D.; published by Doubleday and Company, Inc., Garden City, N. Y., 1960; 170 pages; price, $2.95.

This is a post-humus publication of material collected from magazine articles, speeches, medical papers and taped interviews to fit the notes and outline prepared by Dr. Hilliard. The result does not have the coherence of a book, but reads like a collection of essays. However, the material is of interest to women and represents the thinking of a woman deeply interested in the welfare of other women.

Fatigue can be the result of overwork, for which rest is a simple and apparent treatment. But where loneliness, frustration, or compulsive drive is the cause of fatigue, it is hard to discover and difficult to deal with.

A fundamental cause of fatigue is the lack of understanding of one's physiological pattern. No two people have the same pattern, and until one understands one's own needs and lives according to them, fatigue will result which rest alone cannot relieve. With the recognition of one's physiological pattern, one can then adjust to the stresses of life. We are advised not to fight the demands of life but to recognize them and arrange our routines to include them smoothly, and without irritation.

If a woman will read this small book with understanding and apply herself to the solving of her problems on the lines suggested, life will be easier and happier, with only such fatigue as that which lets one go to sleep at night and get up in the morning refreshed. As Dr. Hilliard says "Women can not only accept, survive and withstand, but can have zest for living throughout their lives."

Alice L. Wakefield, M.D.

FUNDAMENTALS OF CLINICAL HEMATOLOGY: by Byrd S. Leavell, M. D., and Oscar A. Thorup, Jr., M.D., published by W. B. Saunders Company, Philadelphia and London; 503 pages; price, $10.

The field of hematology has been covered in very condensed form in the standard textbooks of medicine and in large, detailed, encyclopedic reference books for those specifically interested in hematology. Between these two extremes, there has not been a satisfactory text which covers the field of practical clinical hematology in a single volume. The authors have written a textbook for medical students and interested practitioners to fill this void.

The result is certainly quite adequate for its purpose. A logical organization outline has been followed and the format is quite attractive. Illustrations are somewhat limited but those which are present are desirably simple and illustrate their points quite well. One of the most desirable features of the book is the bibliography which has obviously been carefully selected to include the most important of the recent and readily available references for those who wish to pursue a subject in more detail.

It is difficult to write a compromise book, and in some areas the subjects are very lightly touched while in other areas the reading becomes somewhat heavy for the avowed purpose of the monograph. The writing style is not as crisp or imaginative as one might like for a book that is intended to be read through, but the points are made with clarity. Illustrated case reports are included at the end of each section and a section on laboratory procedure is included at the end of the book.

This book should prove very useful as a guide for those physicians who are interested in hematological disorders. The authors should be easily able to smooth out the minor inbalance of subject emphasis in future editions and this may well develop into the standard text for introduction to the rapidly growing field of hematology.

Ellis A. Fuller, M.D.

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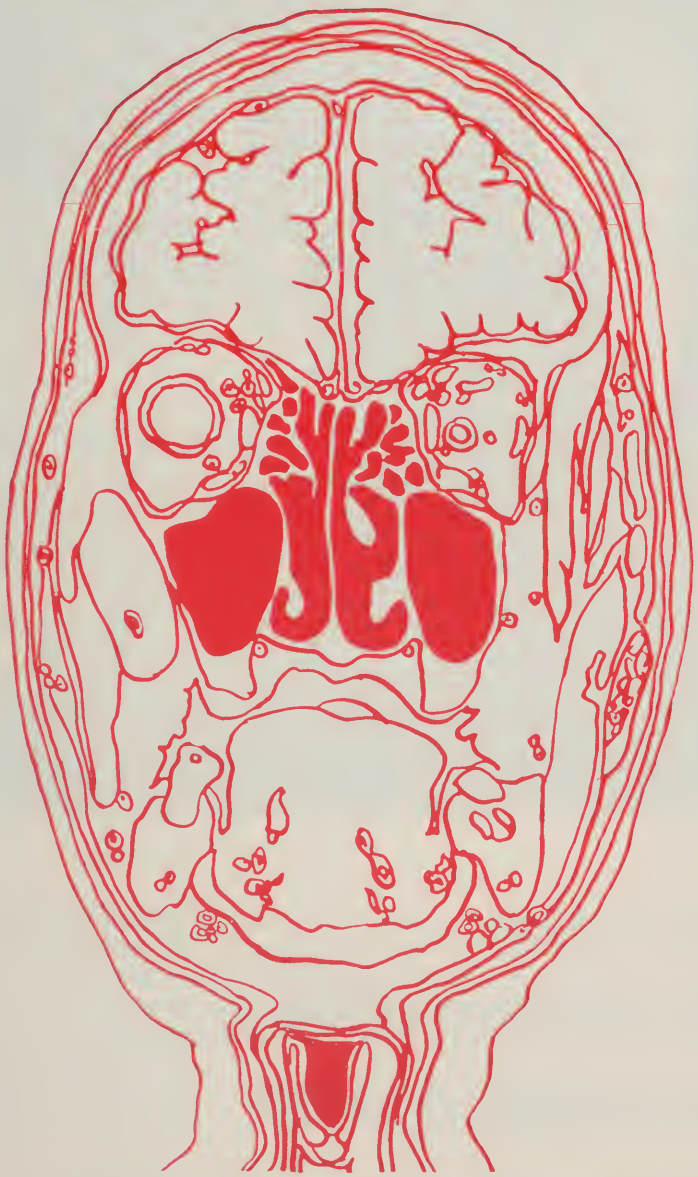
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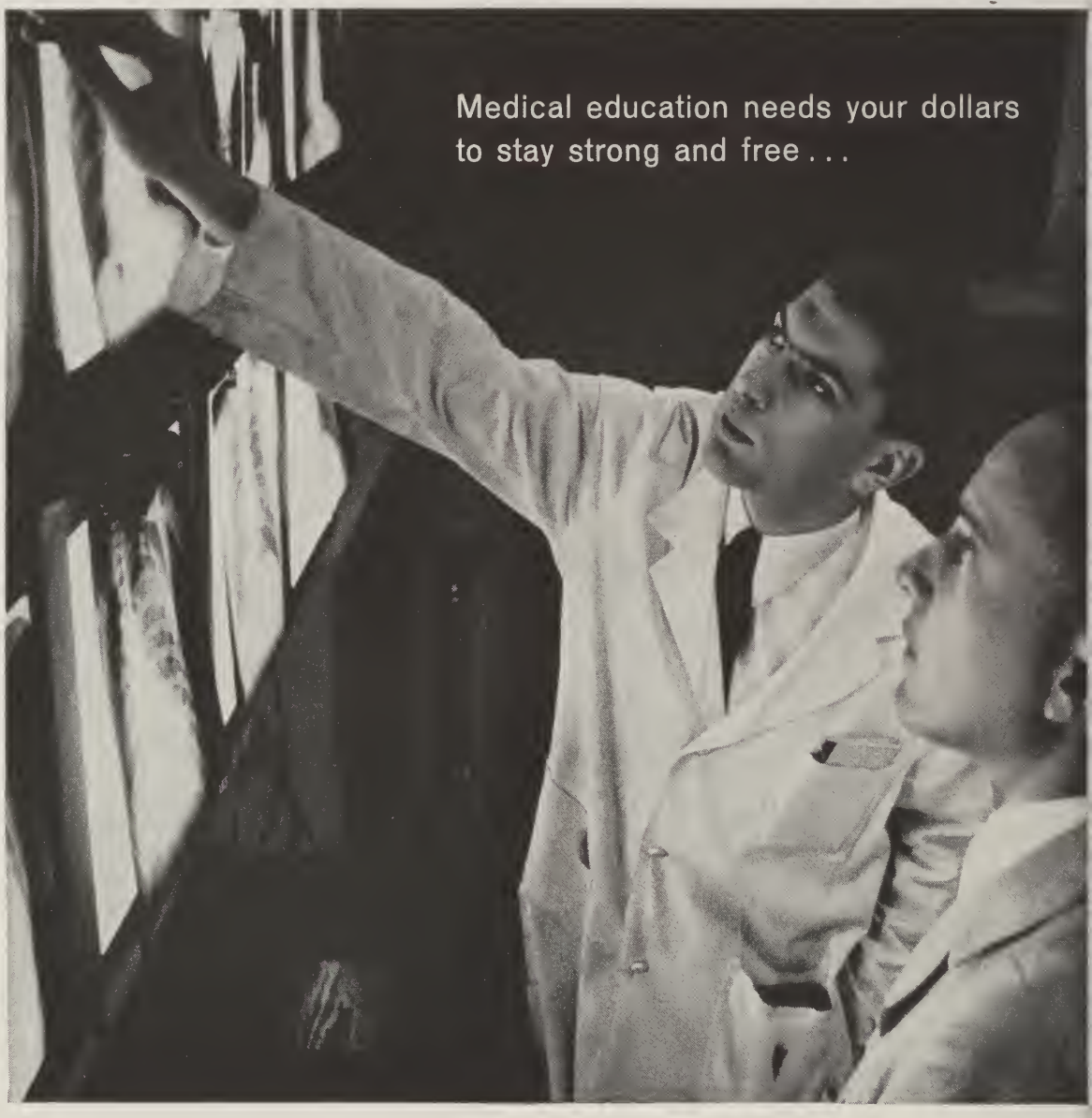


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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



Case # 63

The patient, a 28-year-old married white gravida 6 para 5, did not consult a physician during her pregnancy and very few clinical data could be obtained regarding her. The local health nurse was able to collect only the following information. The date of the last menstrual period was not known. It was known that four of her children were living and that one was dead. Her most recent delivery was performed by a midwife.

The patient was described as a person who did not think medical attention necessary for childbirth. She had swelling of her feet, legs and face, and on the three nights before her death she had complained of "smothering attacks." She apparently died undelivered; the cause of death was listed as eclampsia and cardiac failure. There was no autopsy.

Case # 65

This patient was a 42-year-old married white gravida 11 para 10. She had refused prenatal care and nothing was known of her menstrual history. Following her ninth delivery she had a retained placenta; she was told at that time that any subsequent pregnancy ought to be followed prenatally by a physician and delivered in a hospital.

The local health officer reported she was carried as one of their prenatal cases, and they had informed her she would have to go to the hospital for delivery. When labor began she started to go to the hospital, but decided to return home and call a midwife. When the midwife arrived she tried to persuade the patient to go to the hospital, but without success. The midwife insisted that a physician be called, but the baby, a 9 lb. 2 oz. girl, had been born before the physician arrived.

The physician arrived in time to deliver the placenta; he then massaged the fundus through the thin abdominal wall until it became firmly contracted. An injection of ergotrate was given. The patient was advised to remain in bed until the physician could send back a supply of ergotrate tablets.

The physician said that the patient seems to have died suddenly shortly after his departure. The local health officer pointed out that hospitalization is difficult in the area in question since the only hospital available will no longer admit indigent cases.

The cause of death was listed as uterine hemorrhage due to uterine inertia. It was also stated this patient had placenta previa, even though no such diagnosis was suggested by the clinical data.

Case # 67

This patient was a 40-year-old married white woman who had no prenatal care. The physician who saw her terminally had seen her earlier in false labor in her home, and had advised her to return for an examination and a blood test, but she had not done so. No information was available regarding her past obstetric history.

After spontaneous, unattended delivery of a stillborn infant, the patient was brought to the physician's office because the placenta had not been delivered. She was in shock with no obtainable blood pressure. An attempt was made to start an intravenous infusion, but the patient was dead about five minutes after her arrival in the doctor's office.

No autopsy was performed. The cause of death was listed as "stillbirth at home due to shock of hemorrhage."

Comments

These three patient protocols illustrate the serious consequences which may follow pregnancy episodes in which no prenatal care is provided, and in which adequate hospital and clinic facilities are unavailable when obstetric emergencies arise. It is fallacious to maintain the point of view that the role of the physician in multiparous deliveries is restricted merely to being present for the delivery itself.

A recent study of complications encountered in the grand multipara in Kentucky shows the incidence of complications is about the same as it was in a study made 25 years ago, despite important advances in obstetrics and nationwide reduction of maternal mortality. It is community responsibility to educate patients and to make the best possible use of available medical facilities.

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* In 884 of 1,928 cases the causative organisms were mostly staphylococci. The majority of clinical isolates were found to be resistant to at least one of the commonly used antibiotics and many patients had failed to respond to previous therapy with one or more antibiotics. **TAO proved 93.4% effective in these 884 cases.**

Complete bibliography available on request.

DOSAGE: varies according to severity of infection. Usual adult dose—250 to 500 mg. q.i.d. Usual pediatric dose: 3-5 mg./lb. body weight every 6 hours.

NOTE: In some children, when TAO was administered at considerably higher than therapeutic levels for extended periods, transient-jaundice and other indications of liver dysfunction have been noted. A rapid and complete return to normal occurred when TAO was withdrawn.

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PUBLIC HEALTH PAGE

Fluorescent Antibody Techniques In the Diagnosis Of Communicable Diseases

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health Commonwealth of Kentucky*

THE fluorescent antibody method can be best understood by considering it to be a new way of detecting conventional antigen-antibody reactions. Smears containing antigen are examined under the fluorescence microscope after having been treated with appropriate solutions of fluorescein-labeled antibody.

Applications of fluorscent antibody techniques to the diagnosis and control of communicable disease are still in the early stages of development. Although our concern is primarily diagnostic public health microbiology, recent observations on the seriologic stability of bacterial, protozoan and fungal antigens in tissue processed by the usual histopathological procedures emphasize the increasing importance of fluorescent antibody methods to the pathologist.

Major applications of fluorescent antibody techniques in the past have been limited to studies of fundamental problems primarily concerned with soluable antigens and viruses. The potentialities of this procedure for basic research in the field of microbial cytology are enormous.

The advantages of employing FA tests for diagnostic bacteriological procedures are primarily those of rapidity and sensitivity. Results of tests performed directly on clinical specimens or on cultures are available within the time required to prepare stains and examine the smears, approximately one hour. It is possible to make an identification based on visualization of an exceedingly small number of specifically stained particles of antigen.

A further advantage is that the presence of contaminants is of no concern, if it is known from past experience and from control tests that they will not give false staining reactions. A fourth attribute worthy of mention is the applicability of the FA test to dedection of non-viable pathogens.

The earliest demonstration that the FA tool could be used in the rapid diagnosis of the virus diseases of man came during studies on influenza. The direct staining method, when used to test cellular sediment from nasal washings, resulted in correct diagnosis in 71 per cent of patients with influenza A-prime infections. The chief advantage of the test is its speed; the diagnosis being possible on the same day that the patient is seen.

Even though specific applications of FA techniques in microbiology are possible, there is at present no laboratory in which any test involving FA has replaced a standard test for diagnosis of a communicable disease. This is due to the fact that these tests are in various stages of development and not enough time has elapsed to permit adequate comparisons of FA with conventional tests. Such comparisons will be necessary prerequisites to the adoption of tests based on immunofluorescents as standard procedures.

It should be clear that FA techniques are potentially applicable to any system in which a reaction occurs between antigen and antibody. From the diagnostic point of view, immunofluorescent staining becomes significant only when it has been shown that either unknown antigen or known antibody can be identified rapidly and with a high degree of specificity and senstivity. The technique must be applicable directly to pathological specimens or to agents such as viruses, bacteria, fungi, or protozoa, propagated directly from such material. If identification can be made in the presence of contaminants or after the tissue agent has lost viability, the test becomes still more valuable.

The ability of the test to furnish reliable information under a variety of natural conditions constitutes another advantage. Each system in which FA is employed, therefore, must be evaluated intensively. Immunofluorescence is probably applicable to identification of many communicable diseases and their agents, applications for which as yet no experienced data are available.

Development of rapid identification techniques for the disease processes or their agents would be of great importance to the Public Health Laboratory.

(Continued on Page 1366)

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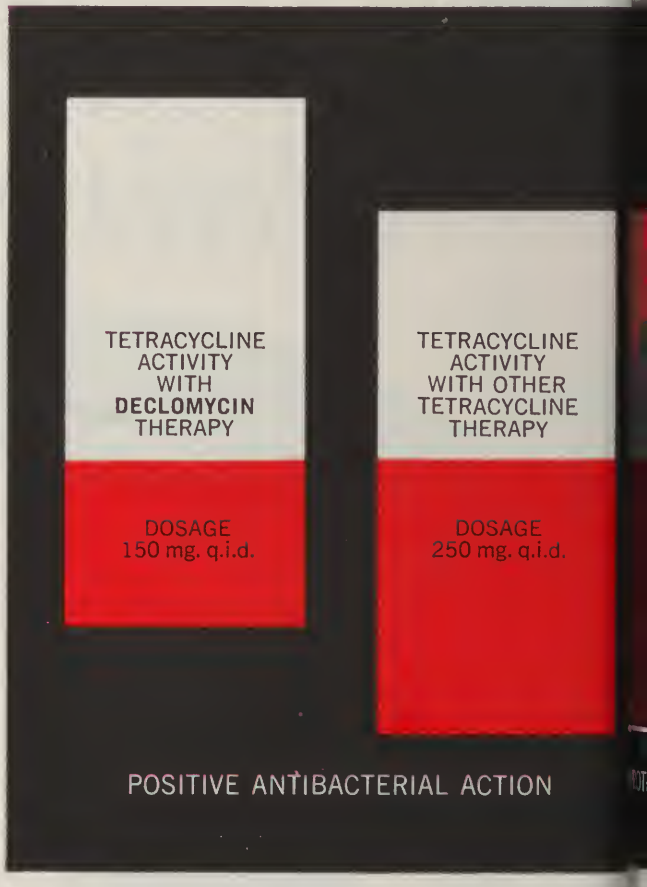
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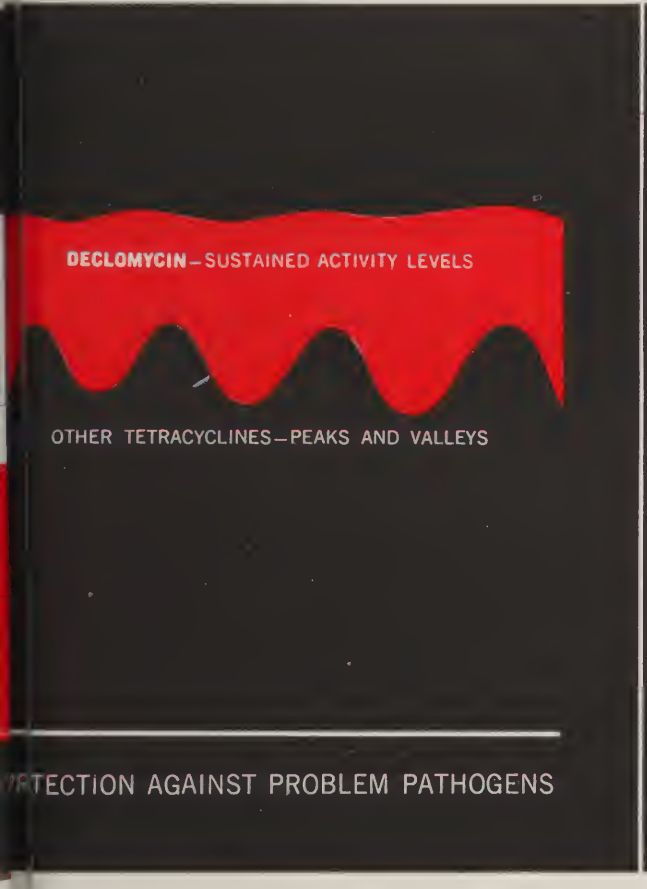
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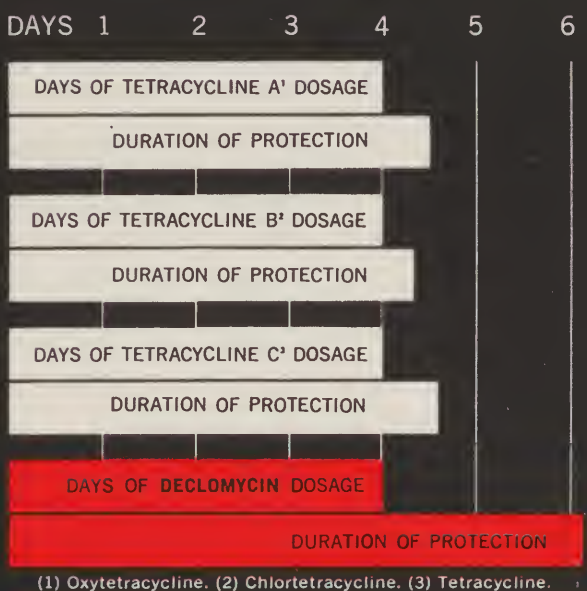
[:CLOMYCIN Demethylchlortetracycline sus-tns, through the entire therapeutic course, the h;h activity levels needed to control the primary i ective process and to check the onset of a com-pcating secondary infection at the original—or at a)ther—site. This combined therapeutic action is sustained, in most instances, without the p)nounced hour-to-hour, dose-to-dose, peak-a l-valley fluctuations in activity levels which c)aracterize other tetracyclines.

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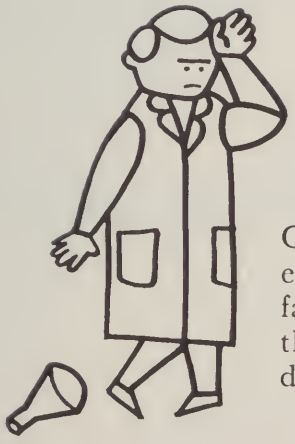
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One pharmaceutical research executive points up the importance of failures as guideposts to success in the search for new or improved drugs when he says:

"Failure is our most important product."

The pharmaceutical industry's investment in research has been growing much faster than the industry itself. Last year the prescription drug companies spent a record $197 million for research, a five-fold increase in the space of ten years. Such an investment is possible, of course, only when there are profits. • This growth in privately financed research has sent the volume of laboratory failures soaring. For two years in a row the pharmaceutical industry has tested more than 100,000 substances in the search for new medicines. Fewer than two per cent showed enough promise for clinical testing. Only a handful will ever be sold as prescription drugs. The odds against finding a product with therapeutic value probably exceeded 2000-to-1. • But year by year, as the failures mount, the successes also increase, putting new or improved medications at the disposal of the medical profession. And the public benefits through better health, specific cures, shorter hospitalization, longer lives. • This is only one part of the massive assault on disease that engages the health team headed by the medical profession and embracing hospitals, nurses, pharmacists, technicians, and colleges. It is an effort that could only take place in a society which encourages individual freedom and guarantees incentives to freedom of enterprise.

This message is brought to you in behalf of the producers of prescription drugs. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D. C.

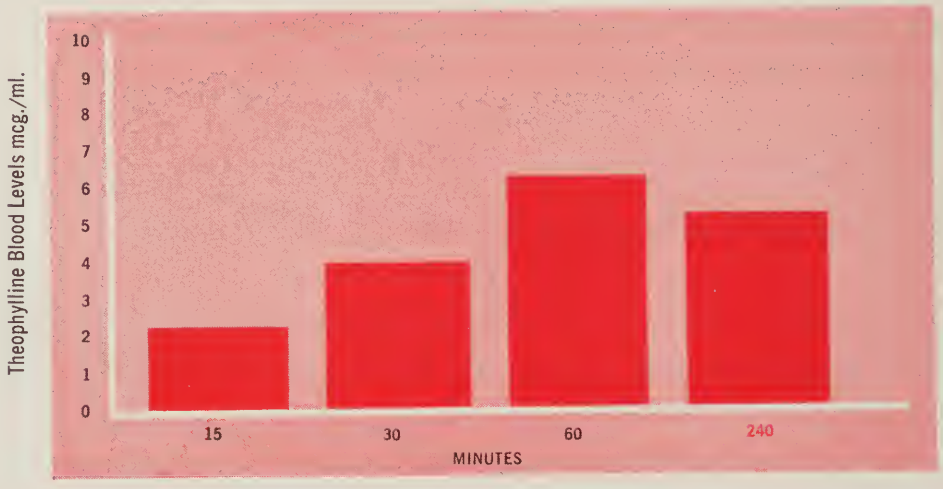
when winter colds provoke episodes of bronchial spasm and congestion

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(Theophylline Sodium Glycinate)

ELIXIR SYNOPHYLATE acts *swiftly* to dilate constricted, edematous bronchi, improve pulmonary ventilation, and increase the lung's vital capacity. Rapidly absorbed, ELIXIR SYNOPHYLATE has been effectively used in acute bronchial asthma, providing *full* therapeutic xanthine levels in about one-half hour, lasting well over four hours after a *single* administration. Wheezing and dyspnea are usually relieved in 5 to 10 minutes.

Significant theophylline blood levels within 15 minutes...persisting for at least 4 hours after SINGLE ORAL DOSE of ELIXIR SYNOPHYLATE



Theophylline sodium glycinate, presented in ELIXIR SYNOPHYLATE, offers superior stability and toleration as compared with other forms of theophylline.[1,2] Thus, ELIXIR SYNOPHYLATE allows *higher, well-tolerated* dosage, where indicated, to achieve *maximum xanthine effect.*

Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) Synophylate (theophylline sodium glycinate), equiv. 0.16 Gm. (2½ gr.) Theophylline U.S.P.; 20% alcohol.
Supplied: Bottles of 1 pint and 1 gallon.

1. A.M.A. Council on Drugs: New and Nonofficial Drugs 1960, Philadelphia, Lippincott, 1960, p. 425. 2. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

Literature on request.
THE CENTRAL PHARMACAL COMPANY
Products Born of Continuous Research • Seymour, Indiana



the complaint: "nervous indigestion"

the diagnosis: any of several nonspecific and functional gastrointestinal disorders requiring relief of symptoms by sedative-antispasmodic action with concomitant digestive enzyme therapy.

the prescription: a new formulation incorporated in an enteric-coated tablet, providing the multiple actions of widely accepted Donnatal® and Entozyme.®

the dosage: two tablets three times a day, or as indicated.

in the gastric-soluble outer layer:

Hyoscyamine sulfate	0.0518 mg.
Atropine sulfate	0.0097 mg.
Hyoscine hydrobromide	0.0033 mg.
Phenobarbital (⅛ gr.)	8.1 mg.
Pepsin, N. F.	150 mg.

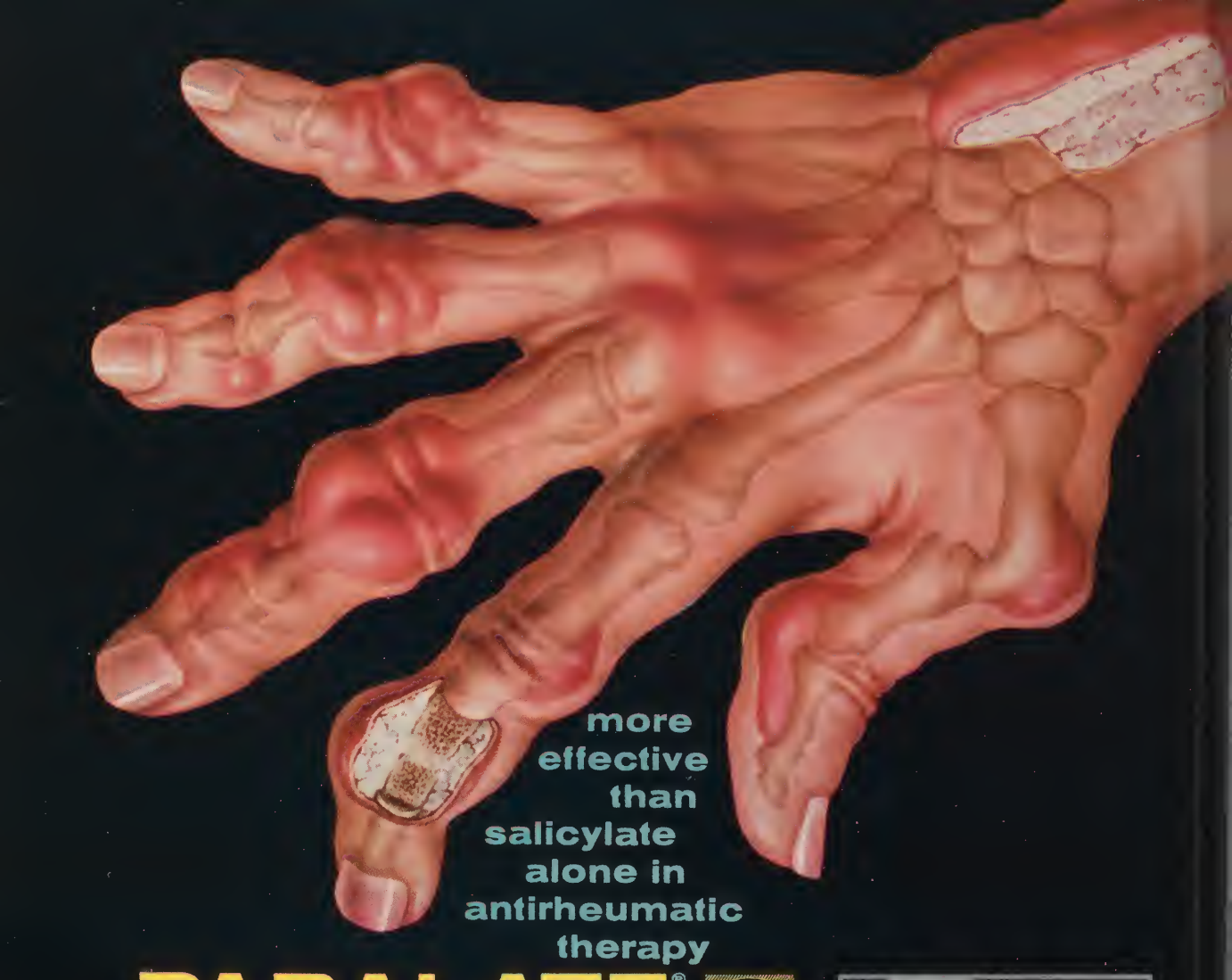
in the enteric-coated core:

Pancreatin, N. F.	300 mg.
Bile salts	150 mg.

antispasmodic • sedative • digestant

DONNAZYME®

A. H. ROBINS COMPANY, INCORPORATED • RICHMOND 20, VIRGINIA



more effective than salicylate alone in antirheumatic therapy

PABALATE®

Robins

COMBINING MUTUALLY SYNERGISTIC NON-STEROID ANTIRHEUMATICS

"superior to aspirin" — ". . . evidence seems to indicate that the concurrent administration of para-aminobenzoic and salicylic acid [as in Pabalate] produces a more uniformly sustained level for prolonged analgesia and, therefore, is superior to aspirin in the treatment of chronic rheumatic disorders."[1]

In each yellow enteric-coated PABALATE tablet:

Sodium salicylate (5 gr.)	0.3 Gm.
Sodium para-aminobenzoate (5 gr.)	0.3 Gm.
Ascorbic acid	50.0 mg.

For the patient who should avoid sodium

PABALATE®-SODIUM FREE

Same formula as Pabalate, with sodium salts replaced by potassium salts (pink)

For the patient who requires steroids

PABALATE®-HC

Pabalate with Hydrocortisone

In each light blue enteric-coated PABALATE-HC tablet:

Hydrocortisone	2.5 mg.
Potassium salicylate (5 gr.)	0.3 Gm.
Potassium para-aminobenzoate (5 gr.)	0.3 Gm.
Ascorbic acid	50.0 mg.

1. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

A. H. ROBINS CO., INC., Richmond 20, Virginia





IN ACNE smooth the skin— cheer the patient

Use of pHisoHex for washing the skin augments any other therapy for acne — brings better results. Now, pHisoAc Cream, a new acne remedy for topical application, suppresses and masks lesions — dries, peels and degerms the skin. Together, pHisoHex and pHisoAc provide **basic** complementary topical therapy for acne.

pHisoHex, antibacterial detergent with 3 per cent hexachlorophene, removes soil and oil better than soap — provides **continuous** degerming action when used often. pHisoHex is nonalkaline, nonirritating and hypoallergenic.

When pHisoAc Cream is used with pHisoHex washings, it unplugs follicles, helps prevent development of comedones, pustules and scarring. New pHisoAc Cream is flesh-toned, not greasy. It contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent, and hexachlorophene 0.3 per cent in a specially prepared base. pHisoAc is pleasant to use.

A new "self-help" booklet, **Teen-aged? Have acne? Feel lonely?,** gives important **psychologic first aid** for patients with acne and describes the proper use of pHisoHex and pHisoAc. Ask your Winthrop representative for copies.

pHisoAc is available in 1½ oz. tubes and pHisoHex is available in 5 oz. plastic squeeze bottles and in bottles of 16 oz.

pHisoHex® and pHisoAc for acne

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LABORATORIES
New York 18, N. Y.



PUBLIC HEALTH PAGE

(Continued from Page 1356)

Probably the greatest problem in the control of communicable disease in the United States today is that of economics. Personnel costs are a major factor in limiting the activities of public health laboratories. The techniques of immunofluorescence promise to allow the laboratory to extend its coverage both qualitatively and quanitatively, thereby rendering more service for a given amount of time and money.

Generally, immuno-chemical methods can be expected to shorten the elapsed time between the receipt of diagnostic specimens and the reporting of the results.

The Kentucky Public Health Laboratories have obtained a fluorescent antibody microscope and have trained personnel to operate this equipment. This equipment will be placed in use on a comparative basis with various other diagnostic tests now being utilized in the laboratory. It is obvious that its uses are extensive and it is hoped that as these tests become acceptable the public health laboratories can offer an even greater service than they are now rendering.

WASHINGTON NEWS

(Continued from Page 1268)

program as soon as possible. But he also said he hopes that Congress in the next session will approve a Republican plan for a supplementary federal-state program to help provide private health insurance for elderly persons who cannot meet their medical expenses.

It appears that the issue probably will arise in Congress next year because some Democrats also have said they will again sponsor legislation that would provide health care for aged persons through the Social Security system.

* * *

THE AMA HAS LAUNCHED a "comprehensive study and action program" to guide Americans in spending their health-care dollars more wisely.

The AMA's new Commission on Medical Care Costs has set out "to find answers to the many questions being raised about medical care costs and to present the findings frankly and forthrightly to the medical profession and to the public."

The program is "dedicated to promoting the highest quality health care at the lowest cost." Louis M. Orr, M.D., of Orlando, Fla., chairman of the commission, said that "any barrier that stands in the way of this objective should be removed—immediately."

One of these barriers is money wasted on ineffective non-prescription or over-the-counter drug products, such as vitamins, food fads, and rheumatism and arthritis remedies. AMA's Council on Foods and Nutrition has estimated that much of the estimated $350 million spent annually on self-prescribed vitamins is wasted.

The AMA is urging physicians to alert their patients and the public to the latent dangers involved in self-prescribing and to the folly of throwing their health-care dollars away on quackeries.



if you're treating coccal infection...

ou can't prescribe a more effective antibiotic than

ERYTHROCIN

Erythromycin, Abbott

w much "spectrum" do you need in treating an ction? Clearly, you want an antibiotic that will w the greatest activity against the offending or- ism, *and the least activity against non-patho- ic gastro-intestinal flora.*

gh these criteria—and make this comparison— n treating your next coccal infection. Erythrocin medium-spectrum antibiotic, notably effective against gram-positive organisms. In this it comes close to being a "specific" for coccal infections — *which means it is delivering a high degree of activity against the majority of common infection-producing bacteria.*

And against many of the troublesome "staph" strains —a group which shows increasing resistance to penicillin and certain other antibiotics—Erythrocin continues to provide bactericidal activity. Yet, as potent as Erythrocin is, *it rarely has a disturbing effect on normal gastro-intestinal flora.* Comes in easy-to-swallow Filmtabs®, 100 and 250 mg. Usual adult dose is 250 mg. every six hours. Children, in proportion to age and weight. Won't you try Erythrocin?

®Filmtab—Film-sealed tablets, Abbott.

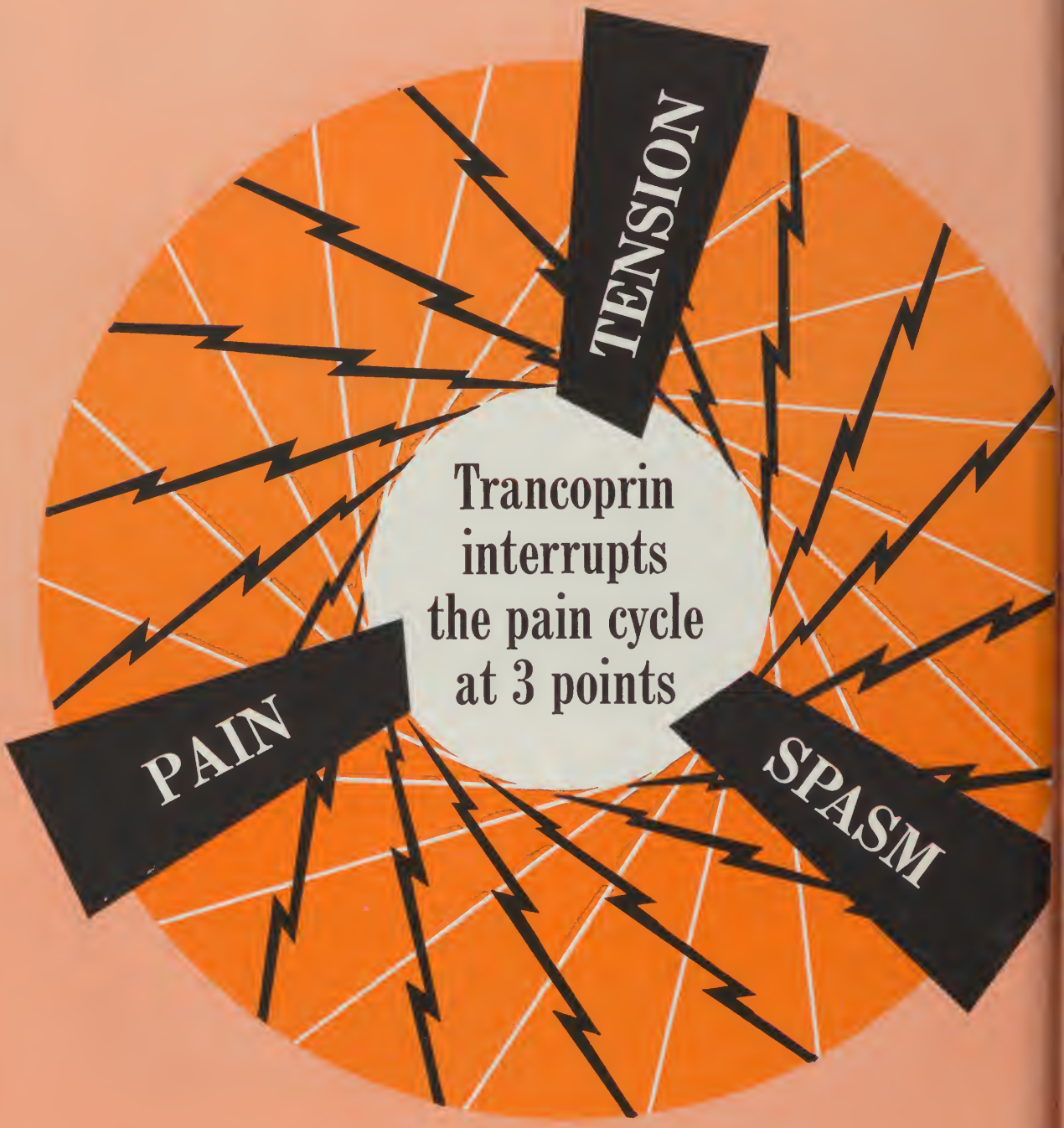
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announcing...

Trancoprin

acetylsalicylic acid (300 mg.) and chlormezanone (50 mg.)

Tablets



a broad spectrum non-narcotic analgesic

Trancoprin, a new analgesic, not only raises the pain perception threshold but, through its chlormezanone component, also relaxes skeletal muscle spasm[1-6] and quiets the psyche.[2,3-5,7]

The effectiveness of Trancoprin has been demonstrated clinically[8] in a number of patients with a wide variety of painful disorders ranging from headache, dysmenorrhea and lumbago to arthritis and sciatica. In a series of 862 patients,[8] Trancoprin brought excellent or good relief of pain to 88 per cent of the group. In another series,[9] Trancoprin was administered in an industrial dispensary to 61 patients with headache, bursitis, neuritis or arthritis. The excellent results obtained prompted the prediction that Trancoprin "... will prove a valuable and safe drug for the industrial physician."[9]

Exceptionally Safe

No serious side effects have been encountered with Trancoprin. Of 923 patients treated with Trancoprin, only 22 (2.4 per cent) experienced any side effects.[8,9] In every instance, these reactions, which included temporary gastric distress, weakness or sedation, were mild and easily reversed.

Indications

Trancoprin is recommended for more comprehensive control of the pain complex (pain → tension → spasm) in those disorders in which tension and spasm are complicating factors, such as: headaches, including tension headaches / premenstrual tension and dysmenorrhea / low back pain, sciatica, lumbago / musculoskeletal pain associated with strains or sprains, myositis, fibrositis, bursitis, trauma, disc syndrome and myalgia / arthritis (rheumatoid or hypertrophic) / torticollis / neuralgia.

Dosage

The usual adult dosage is 2 Trancoprin tablets three or four times daily. The dosage for children from 5 to 12 years of age is 1 tablet three or four times daily. Trancoprin is so well tolerated that it may be taken on an empty stomach for quickest effect. The relief of symptoms is apparent in from fifteen to thirty minutes after administration and may last up to six hours or longer.

How Supplied

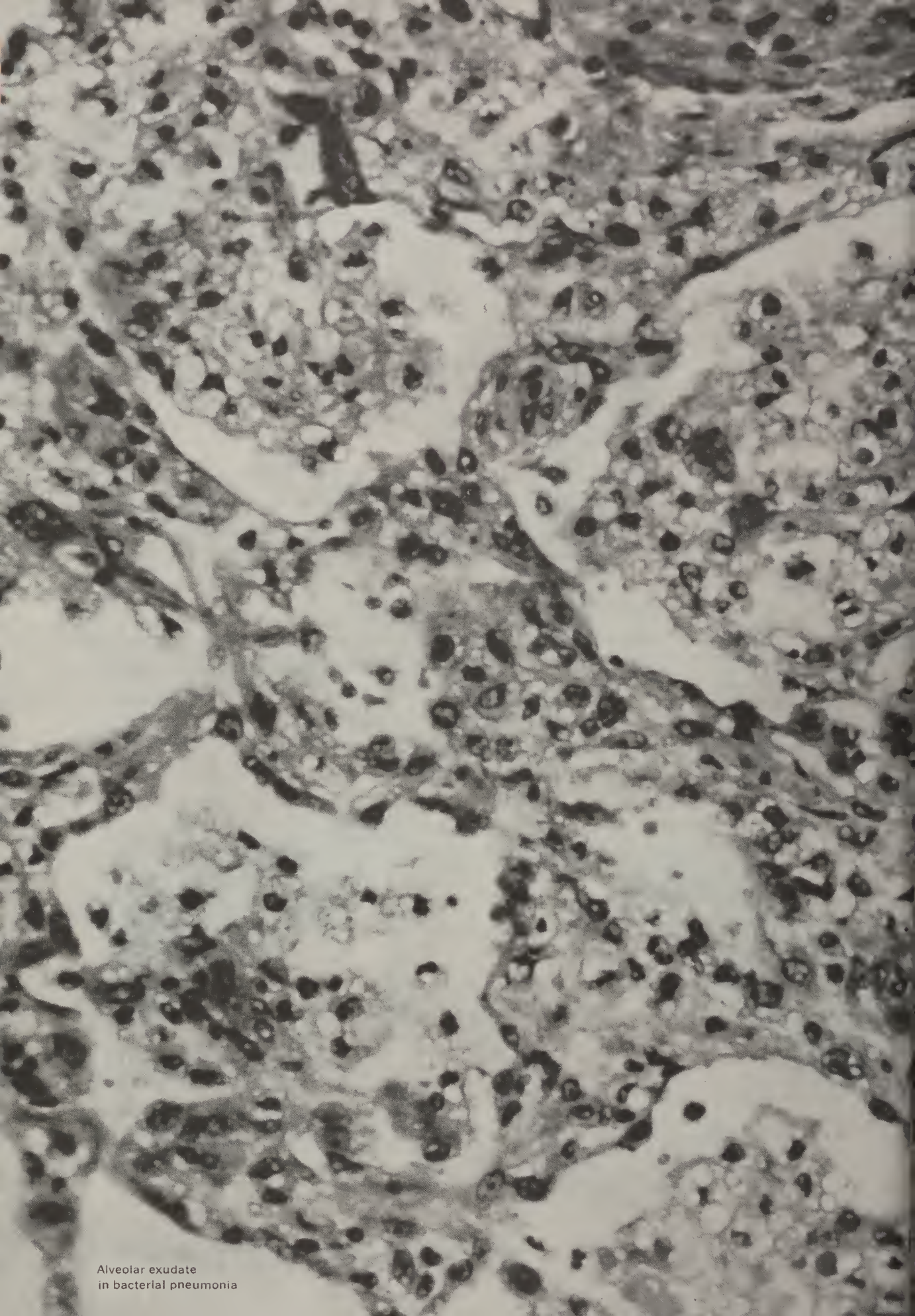
Each Trancoprin tablet contains 300 mg. (5 grains) of acetylsalicylic acid and 50 mg. of chlormezanone [Trancopal® brand]. Bottles of 100 and 1000.

Trancoprin Tablets / non-narcotic analgesic

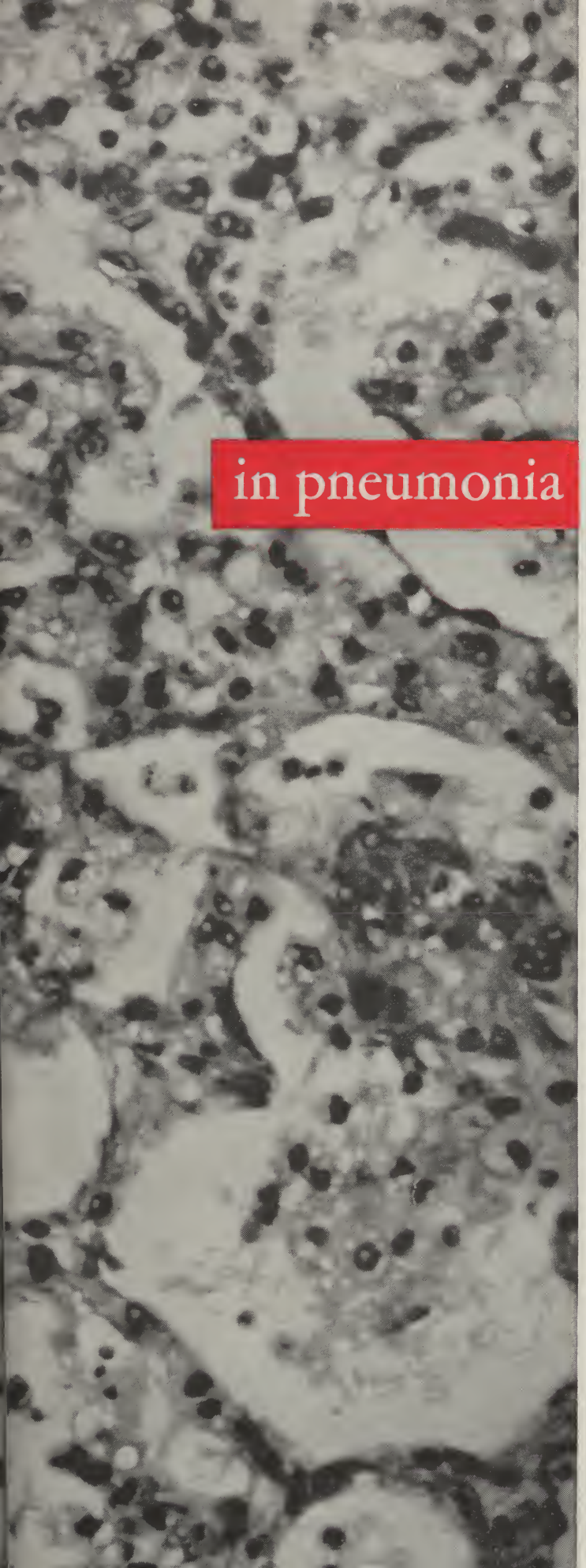
References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

Winthrop LABORATORIES, New York 18, N. Y.

Trancoprin and Trancopal (brand of chlormezanone) trademarks reg. U.S. Pat. Off.



Alveolar exudate
in bacterial pneumonia



in pneumonia

Therapeutic confidence

Panalba is effective against more than 30 commonly encountered pathogens including staphylococci resistant to other antibiotics. Right from the start, prescribing it gives you a high degree of assurance of obtaining the desired anti-infective action in this as in a wide variety of bacterial diseases.

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

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your broad-spectrum antibiotic of *first* resort

new clinical study[1] cites beneficial results in over 90% of cases in dry, itchy, scaly skin with Sardo®

in the bath

Use of **SARDO** in 118 dermatological patients to relieve dry, itchy, scaly, fissured skin achieved these excellent results:

CASES	AFTER SARDO*		
	Excellent	Good	Poor
49 Senile skin	32	13	4
26 Dry Skin in younger patients (diabetes, etc.)	14	11	1
20 Atopic dermatitis	8	10	2
13 Actinic changes	9	4	—
10 Ichthyosis	3	4	3
Skin Conditions	Benefited	No Benefit	
20 Nummular dermatitis	19	1	
10 Neurodermatitis	10	—	



SARDO acts[1,2] to (A) lubricate and soften skin, (B) replenish natural emollient oil, (C) prevent excessive evaporation of essential moisture.

SARDO releases millions of microfine water-miscible globules to provide a soothing suspension which enhances the efficacy of your other therapy.

SARDO is pleasant, convenient, easy to use; non-sticky, non-sensitizing. Bottles of 4, 8 and 16 oz.

for **SAMPLES** and complete reprint of Weissberg paper, please write . . .

1. Weissberg, G.: Clin. Med., June 1960.

2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.

*patent pending
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In active people who won't take time to eat properly, MYADEC can help prevent deficiencies by providing comprehensive vitamin-mineral support. Just one capsule a day supplies therapeutic doses of 9 important vitamins plus significant quantities of 11 essential minerals and trace elements. MYADEC is also valuable in vitamin depletion and stress states, in convalescence, in chronic disorders, in patients on salt-restricted diets, or wherever therapeutic vitamin-mineral supplementation is indicated.

Each MYADEC Capsule contains: VITAMINS: Vitamin B_{12} crystalline—5 mcg.; Vitamin B_2 (riboflavin)—10 mg.; Vitamin B_6 (pyridoxine hydrochloride)—2 mg.; Vitamin B_1 mononitrate—10 mg.; Nicotinamide (niacinamide)—100 mg.; Vitamin C (ascorbic acid)—150 mg.; Vitamin A—(7.5 mg.) 25,000 units; Vitamin D—(25 mcg.) 1,000 units; Vitamin E (d-alpha-tocopheryl acetate concentrate)—5 I.U. MINERALS: (as inorganic salts) Iodine—0.15 mg.; Manganese—1 mg.; Cobalt—0.1 mg.; Potassium—5 mg.; Molybdenum—0.2 mg.; Iron—15 mg.; Copper—1 mg.; Zinc—1.5 mg.; Magnesium—6 mg.; Calcium—105 mg.; Phosphorus—80 mg. Bottles of 30, 100 and 250.

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then back
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nutritional
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not far behind.
prescribe...

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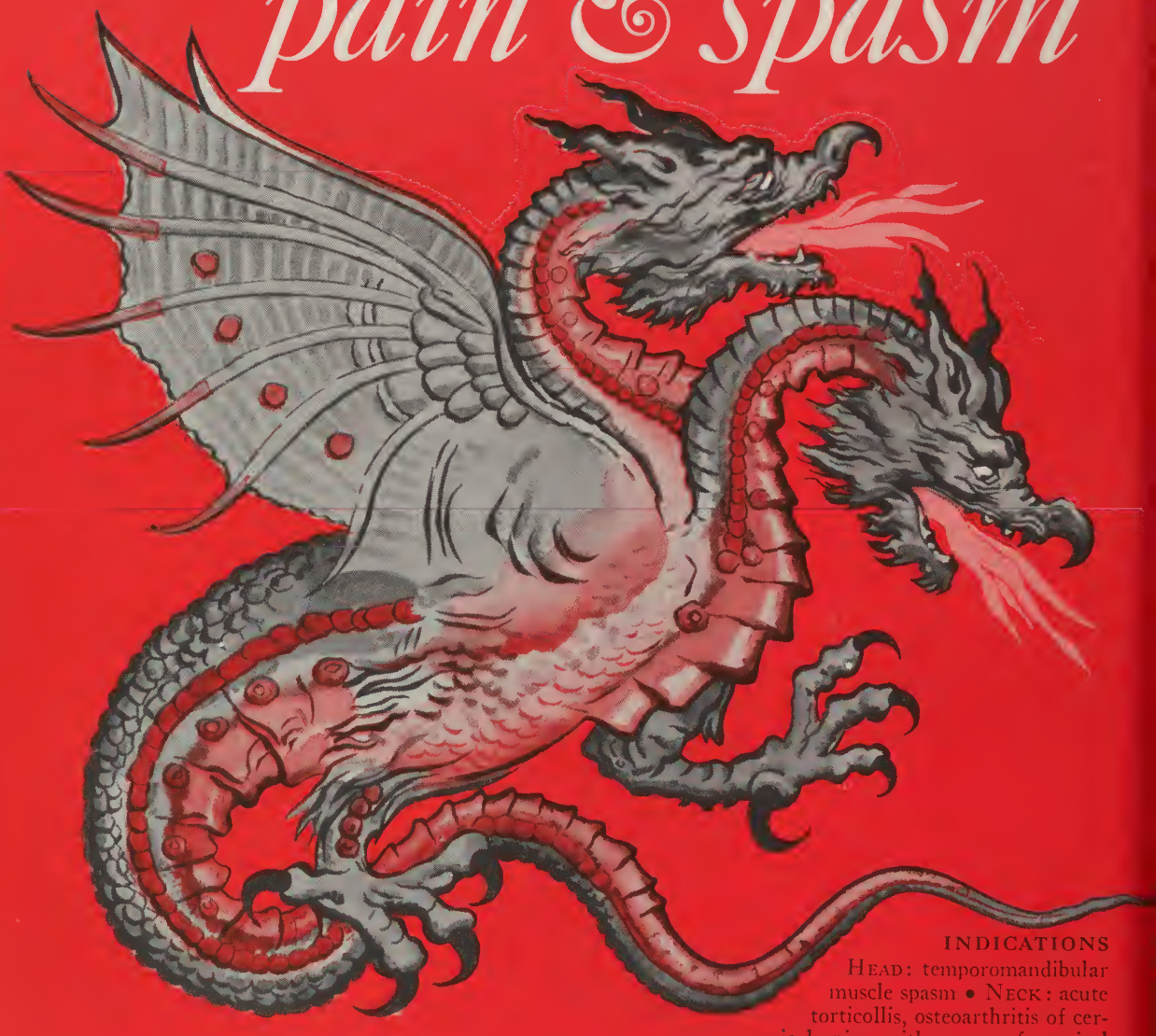
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now—for more comprehensive control of

'pain & spasm'



INDICATIONS

HEAD: temporomandibular muscle spasm • NECK: acute torticollis, osteoarthritis of cervical spine with spasm of cervical muscles, whiplash injury • TRUNK AND CHEST: costochondritis, intercostal myositis, xiphodynia • BACK: acute and chronic lumbar strains and sprains, acute low back pain (unspecified), acute lumbar arthritis and traumatic injury, compression fracture, herniated intervertebral disc, post-disc syndrome, strained muscle(s) • EXTREMITIES: acute hip injury with muscle spasm, ankle sprain, arthritis (as of foot or knee), blow to shin followed by muscle spasm, bursitis, spasm or strain of muscle or muscle group, old fracture with recurrent spasm, Pellegrini-Stieda disease, tenosynovitis with associated pain and spasm.

-pain due to
or associated with
-spasm of skeletal muscle

a new muscle relaxant-analgesic



Robaxisal®

ROBAXIN® WITH ASPIRIN

Many conditions, painful in themselves, often give rise to spasm of skeletal muscles. ROBAXISAL, the new dual-acting muscle relaxant-analgesic, treats both the pain and the spasm with marked success: In clinical studies on 311 patients, 12 investigators[1] reported satisfactory results in 86.5%. Each ROBAXISAL Tablet contains:

- A relaxant component — Robaxin* — widely recognized for its prompt, long-lasting relief of painful skeletal muscle spasm, with unusual freedom from undesired side effects . . . . . 400 mg.

*Methocarbamol Robins. U.S. Pat. No. 2770649

- An analgesic component—aspirin — whose pain-relieving effect is markedly enhanced by Robaxin, and which has added value as an anti-inflammatory and anti-rheumatic agent . . . . (5 gr.) 325 mg.

SUPPLY: ROBAXISAL Tablets (pink-and-white, laminated) in bottles of 100 and 500.

Also available: ROBAXIN Injectable, 1.0 Gm. in 10-cc. ampul. ROBAXIN Tablets, 0.5 Gm. (white, scored) in bottles of 50 and 500.

. . . or when anxiety accompanies pain and spasm: **ROBAXISAL®-PH** (Robaxin® with Phenaphen®). Sedative-enhanced analgesic and skeletal muscle relaxant. Each two white-and-green laminated ROBAXISAL-PH tablets contain: methocarbamol 800 mg., plus the equivalent of one Phenaphen capsule (phenacetin 194 mg., acetylsalicylic acid 162 mg., hyoscyamine sulfate 0.031 mg., and ¼ gr. phenobarbital 16.2 mg.). Bottles of 100 and 500.

[1]Clinical reports in files of A. H. Robins Co., Inc., from: J. Allen, Madison, Wisc., B. Billow, New York, N. Y., B. Decker, Richmond, Va., C. Freeman, Jr., Augusta, Ga., R. B. Gordon, New York, N. Y., J. E. Holmblad, Schenectady, N. Y., L. Levy, New York, N. Y., N. LoBue, Chicago Heights, Ill., H. Nachman, Richmond, Va., A. Poindexter, Los Angeles, Cal., E. Rogers, Brooklyn, N. Y., K. H. Strong, Fairfield, Ia.

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(reserpine CIBA)

One reason that many cases of hypertension respond to Serpasil is that many cases are associated with stress. Stress situations produce stimuli which pass through the sympathetic nerves, constricting blood vessels, and increasing heart rate. Hyperactivity of the sympathetic nervous system may elevate blood pressure; if prolonged, this may produce frank hypertension. By blocking the flow of excessive stimuli to the sympathetic nervous system, Serpasil guards against stress-induced vasoconstriction, brings blood pressure down slowly and gently.

In mild to moderate hypertension, Serpasil is basic therapy, effective alone "...in about 70 per cent of cases..."*

In severe hypertension, Serpasil is valuable as a primer. By adjusting the patient to the physiologic setting of lower pressure, it smooths the way for more potent antihypertensives.

In all grades of hypertension, Serpasil may be used as a background agent. By permitting lower dosage of more potent antihypertensives, Serpasil minimizes the incidence and severity of their side effects.

CIBA
SUMMIT, N. J.

*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955. /2830M8

Complete information available on request.



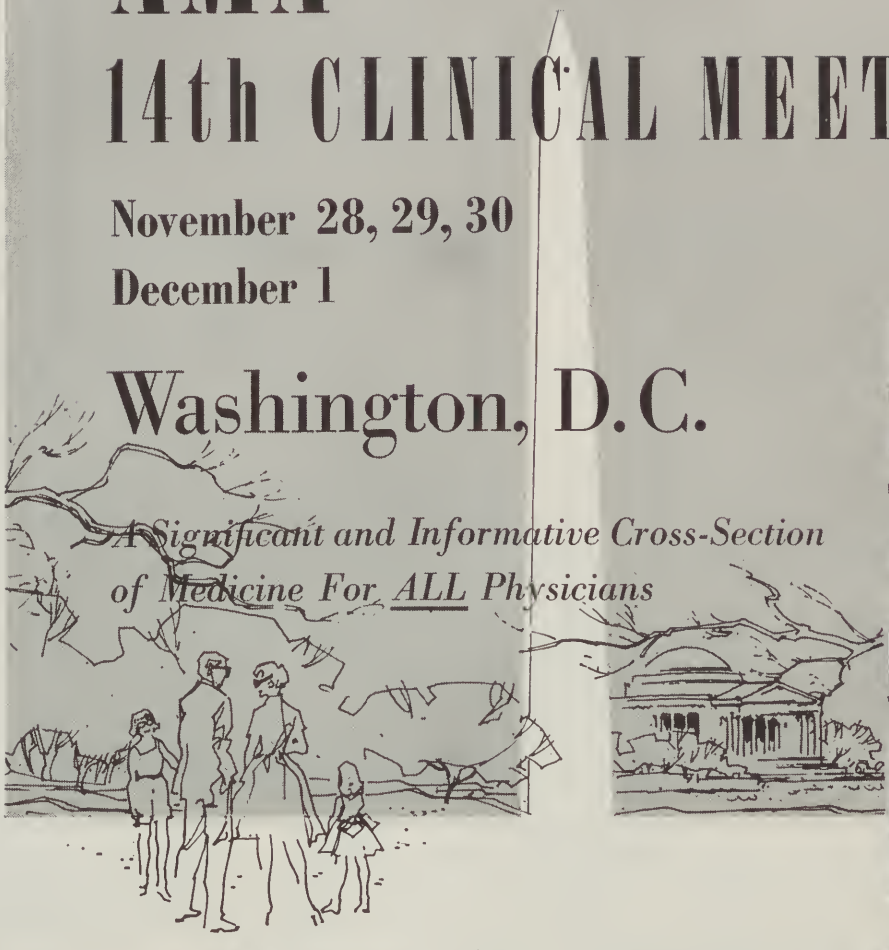
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November 28, 29, 30
December 1

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A Significant and Informative Cross-Section of Medicine For ALL Physicians





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OUR NATION'S historic capital city will be the setting for the American Medical Association's 14th Clinical Meeting November 28 through December 1.

The program—planned to interest and inform every physician—features the latest medical developments presented in panel discussions, symposiums, round table sessions, lectures, closed circuit telecasts and motion pictures. Many scientific and industrial exhibits will be on display.

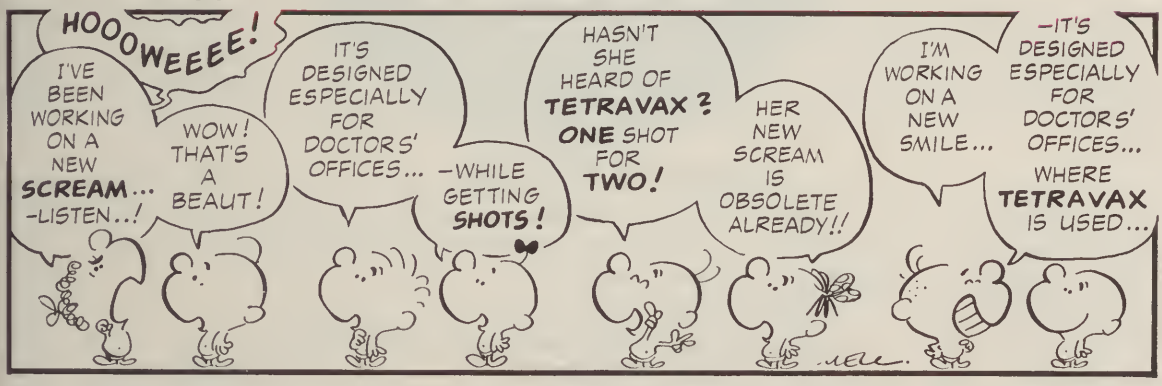
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now you can immunize against more *diseases...with* fewer *injections*

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Robert C. Long, 806 Heyburn Building, Louisville	Jan. 1, 1959-Dec. 31, 1960
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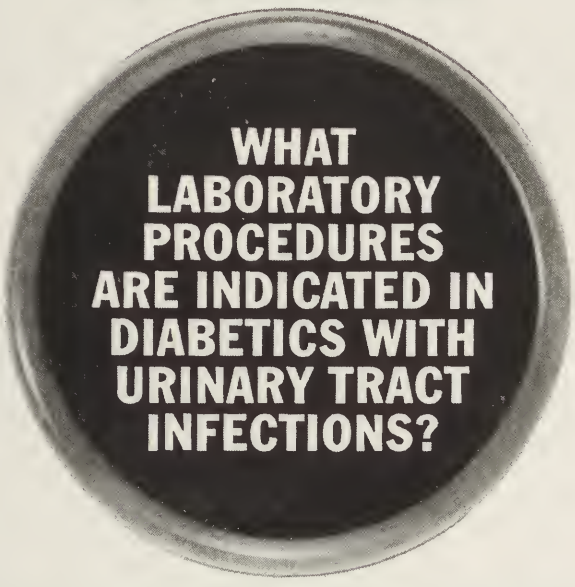
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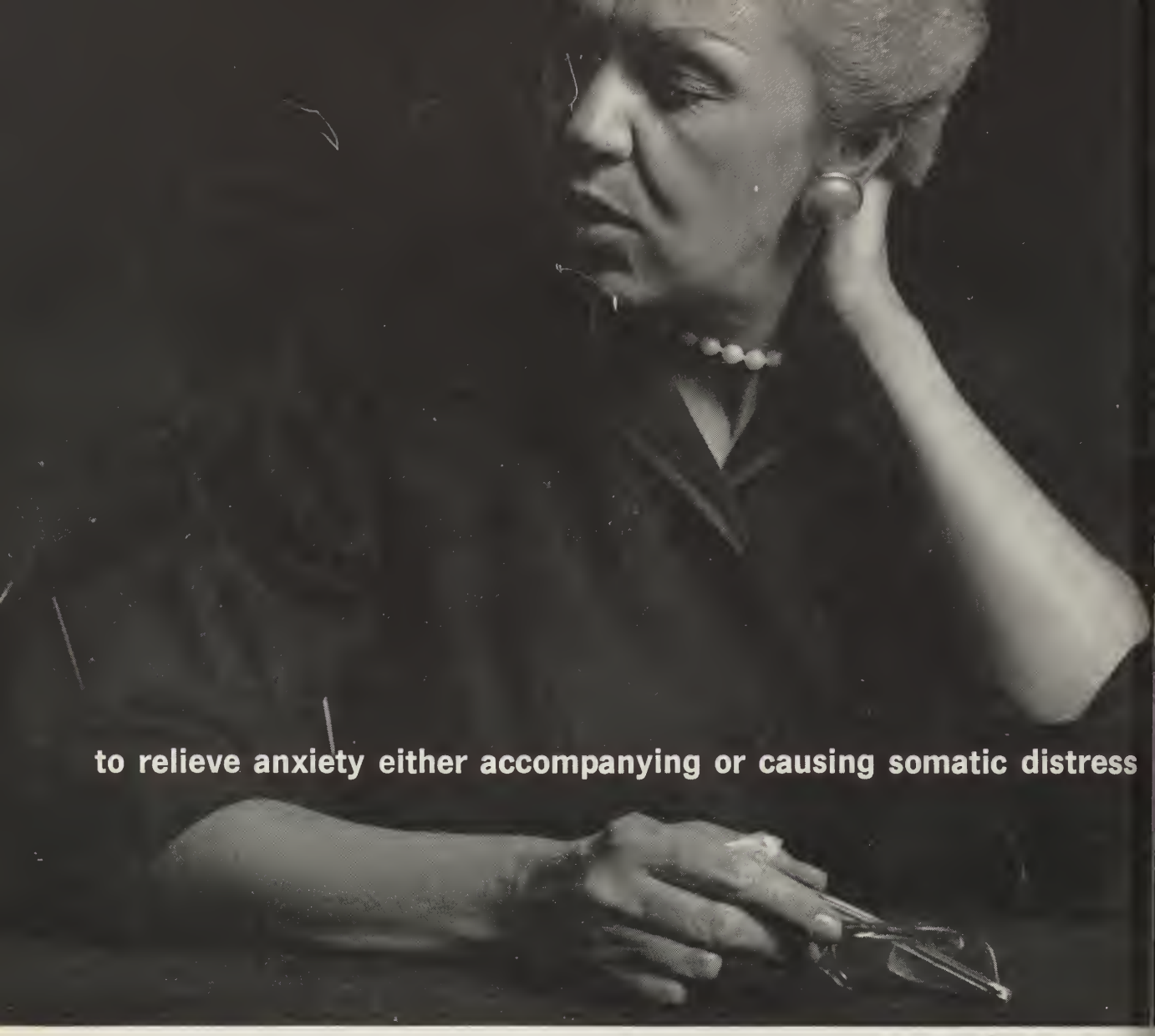
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1. Marx, F.J., in *Trifluoperazine: Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959, p. 89.
2. Winkelman, N.W., Jr.: *ibid.*, p. 78.

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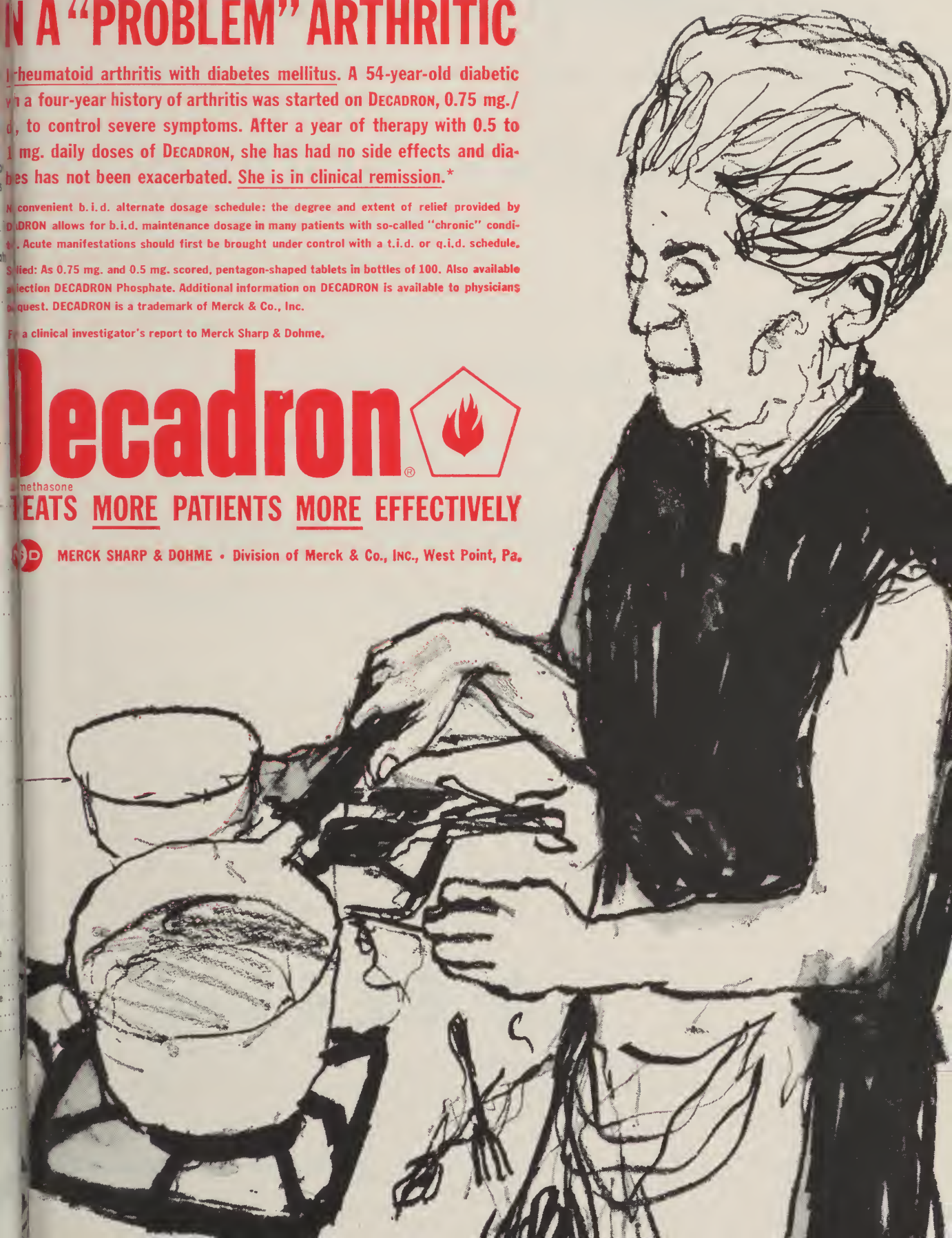
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MESSAGE FROM THE PRESIDENT

THE month of September, 1960, saw medicine in Kentucky take two strides forward. The College of Medicine of the University of Kentucky opened its doors to the first class and the KSMA took the first steps toward constructing and owning its own building and home.

The University of Kentucky for many years has had as one of its objectives the establishment of a College of Medicine. It was not until the last decade that these plans took concrete form and the Legislature appropriated the funds for a Medical Center which should train not only physicians but nurses, dentists, and various medical technicians.

Dean Willard and his associates have planned and worked for three years and the first unit of the Center, the Medical Science Building, was completed this summer. It is a beautiful building and functionally adapted to changes which may be necessary in medical teaching in the years to come. There is at present a medical library of 50,000 volumes and files of over 11,000 different journals from many countries. The hospital will open in 1962. The first class is made up of forty students which will be increased over the next few years to a freshman class of seventy-five annually. This Medical Center is a structure of which all Kentuckians may be proud and, if the teaching program is as well done as the building program, the State should have two great medical schools.

During the past year a committee composed of Drs. George Brockman, Lewis Bosworth and Hoyt Gardner studied possible locations for a KSMA building in Louisville and other Kentucky cities, architects' plans and cost estimates for a building to fit our needs and visited a number of new state medical society buildings in our sister states. Their report was a model of completeness and clarity. The House of Delegates at the September meeting authorized the officers of the KSMA to proceed "with due deliberate speed" to have the building built. The site chosen is on the Taylorsville Road just off the Watterson Expressway.

It is felt that the plans can be approved this winter, construction can start in the early spring and the building be ready for occupancy in about fourteen months. This is to be done without increasing dues or assessing the membership. Such an attractive building should be a great asset to KSMA, giving our home office force ample workroom and providing a meeting place for the Board of Trustees and our many committees as well as being a sound investment.

Kentucky medicine in the month of September, 1960, has indeed taken two strides forward.

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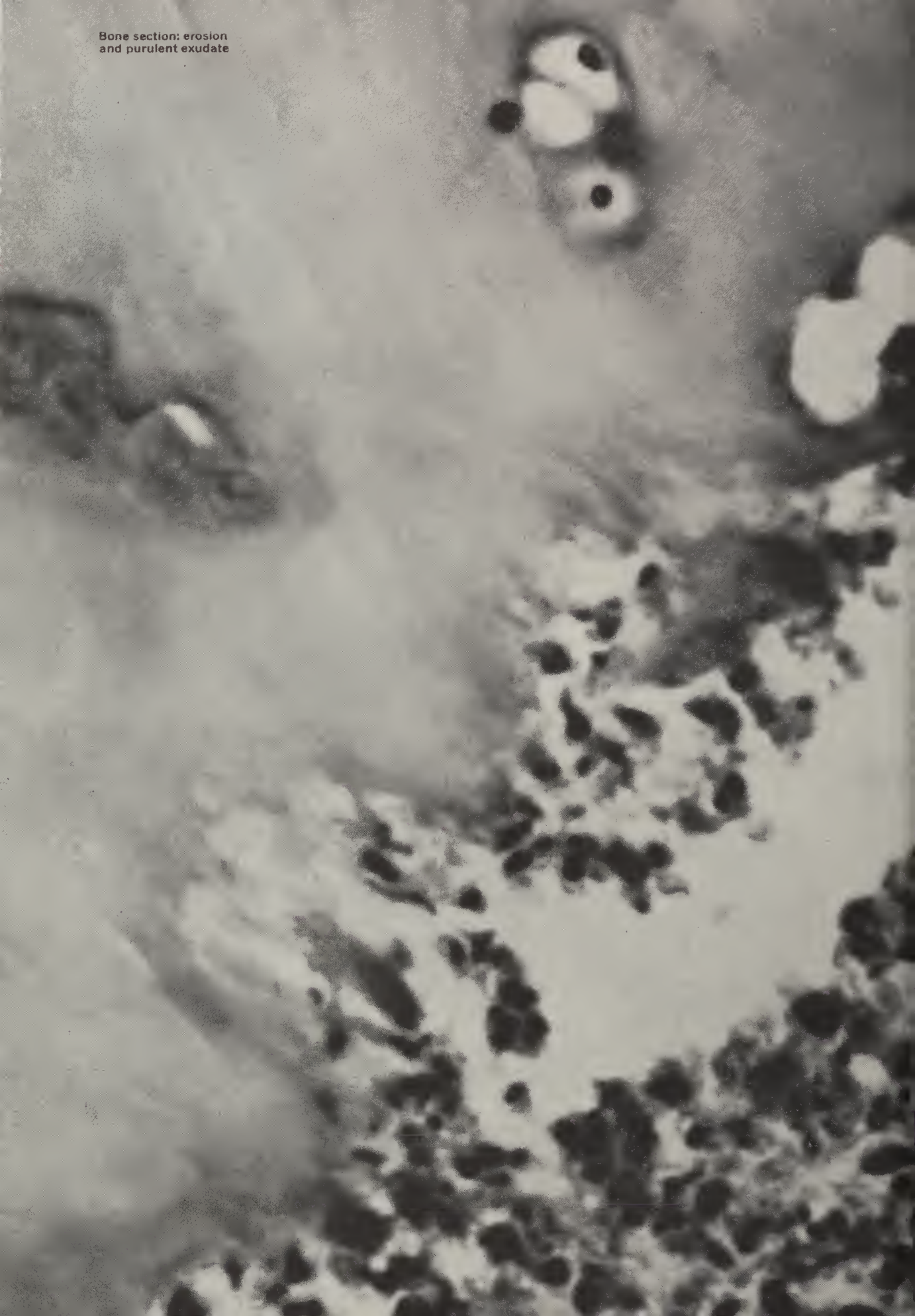


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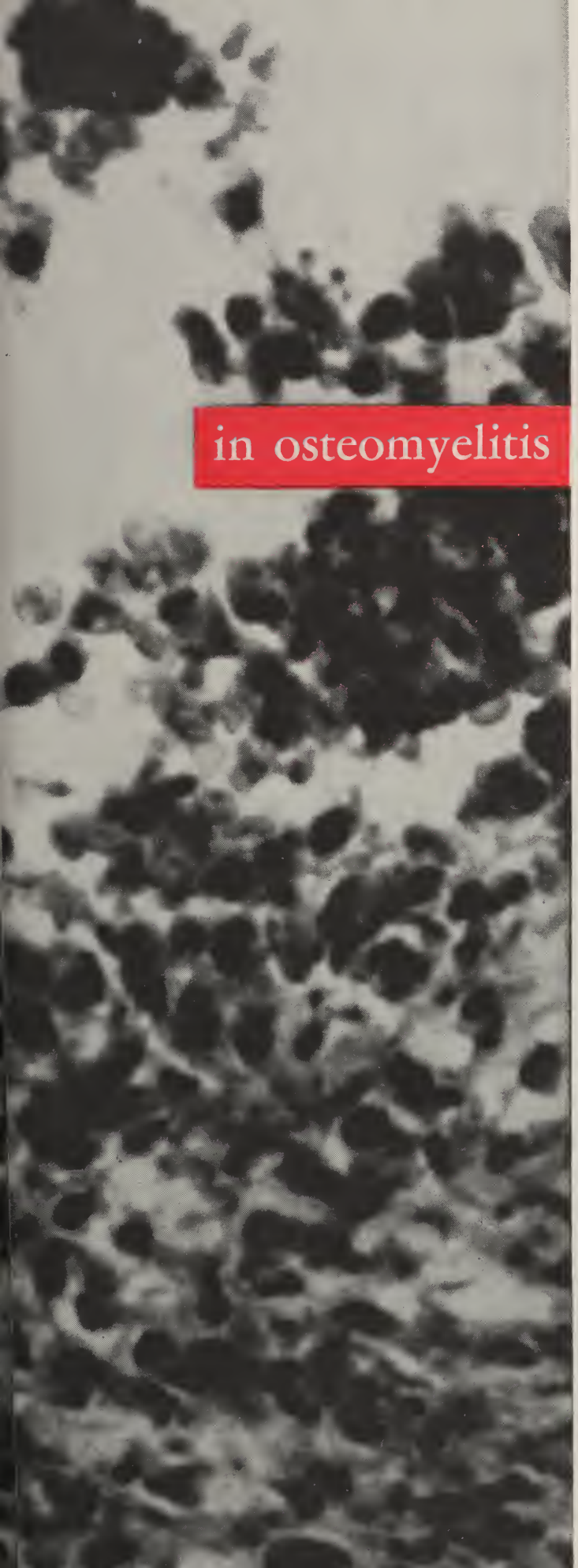
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*Reports to Department of Clinical Investigation, Parke, Davis & Company, 1958 and 1959.

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THE INSURANCE PAGE



THE 1960 Presidential election is a matter of history. By a decision of a majority of the voters of the nation, Senator John F. Kennedy is now our President-elect.

One of the major planks in the platform on which Senator Kennedy ran was that of providing health care for our senior citizens through the use of Social Security funds, with no regard as to whether each individual was able to provide such care for himself.

The vast majority of physicians throughout the United States were and still are opposed to this method of providing health care for the older people. We believe, and correctly so, that such a program could eventually lead to governmental provision and control of all health services in this country.

The narrowness of the margin by which the election was decided certainly would seem to indicate that Mr. Kennedy has received no mandate from the people to move full steam ahead with his entire welfare program. His failure to rack up a popular vote landslide will reduce the willingness of conservative minded lawmakers to go along with his more radical proposals.

Now is the time, then, for the medical profession to renew its fight against the Social Security approach to health care for the aged and, even more important, to resist attempts to extend compulsory health care to other segments of our population.

There are important things which we, as physicians, must do to help prevent the development of a compulsory health program in this country.

We can use every legitimate means to persuade our legislators to oppose such a program.

Each of us can devote more time in trying to convince our own patients that the voluntary method of prepaying for health care is better and less costly than any governmental scheme will be.

We should energetically support our voluntary health plans, especially Blue Cross and Blue Shield. We must constantly work to improve the coverage and services offered by these plans, so that there will be less and less demand for government to step into the field.

Many of the private insurance organizations are also doing an excellent job of providing prepayment mechanisms for financing health care, and these, too, deserve our support and cooperation.

Any prepayment plan that does not provide protection throughout life's span, regardless of age or physical condition, is creating medical economic problems—not solving them.

People must be encouraged to buy protection that can be continued throughout life's span regardless of age or physical condition.

Last, but not least, we must avoid a feeling of defeatism, and must not yield to a tendency to abandon the fight for the preservation of our freedoms.

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WASHINGTON NEWS DIGEST

Washington, D. C.—Election of Sen. John F. Kennedy as President made it probable that the issue of providing health care for the aged under Social Security again will be raised in Congress next year.

Kennedy will go into the White House pledged "to the immediate enactment of a program of medical care for the aged through Social Security." His intentions present a serious challenge to the nation's physicians who have vigorously opposed use of the Social Security system to provide health care for the aged.

Kennedy's program would provide what he described as "a life policy of paid-up medical insurance" for older persons. "It would provide them hospital benefits, nursing home benefits and X-rays and laboratory tests on an out-patient basis," he said in his campaign for the Presidency.

He said the Kerr-Mills legislation enacted into law last summer is inadequate. The medical profession supports this federal-state program to provide health care for needy and near-needy aged persons. In approving the Kerr-Mills program, Congress rejected the Social Security approach espoused by Kennedy and union labor leaders.

Kennedy's medical program also included: federal grants for construction, expansion and modernization of medical, dental and public health schools; federal loans and scholarships for medical students; federal grants for renovating older hospitals; increased federal financial support for medical research, including basic research, and expansion of federal programs for rehabilitation of handicapped or disabled persons.

•

FOOD AND DRUG ADMINISTRATION employes have been cleared of conflict-of-interest charges brought up in the Senate Antitrust and Monopoly Subcommittee's investigation of the drug industry.

A three-member investigating group appointed by Arthur S. Flemming, Secretary of Health, Education and Welfare, examined the financial records of 900 FDA employes. The special investigators then reported:

"On the basis of all the evidence before us, it is our judgment that there are no present employes of the FDA whose sources of personal income are incompatible with their government employment."

The investigators continued to analyze "a mass of fact and opinion" in connection with charges that there has been too close a relationship between some FDA employes and drug companies which they check for conformance to government regulations.

The investigators anticipated that their final report would show the possibility of organization or procedural improvements in the FDA.

The charges were triggered by disclosure at the Subcommittee investigation that Dr. Henry A. Welch, Director of the FDA's Antibiotics Division, had received $287,000 over eight years as a writer and editor for antibiotics publications. After the disclosure, Flemming ousted Welch from the government post.

•

THE FEDERAL CHILDREN'S BUREAU reported that the infant death rate in the United States has declined since 1958 but still shows the effect of a 1957-58 setback.

There was a steady decline in U.S. infant deaths during the 1950's but increases in 1957 and 1958. Since then, the infant death rate has headed downward again but still hasn't made up the lost ground, even though the provisional rates for 1959 (26.4 deaths under one year per 1,000 live births) and the first half of 1960 (25.9 per 1,000) showed improvements.

In 1915, when data was first gathered on infant mortality in this country, the rate was 99.9 per 1,000. By 1940, this had been cut to 47 and by 1950, it had been reduced to 29.2.

An all-time low of 26 was registered in 1956. It edged up to 26.3 in 1957 and 27.1 in 1958.

According to the 1959 United Nations Demographic Yearbook, nine other countries reported lower infant mortality rates than the United States in 1958. They were: Sweden 15.8, Netherlands 17.2, Australia 20.5, Norway 20.5, Switzerland 22.2, United Kingdom 23.3, Denmark 23.4, New Zealand 23.4 and Finland 24.5.

Russia reported a rate of 81 in 1950 and 40.6 in 1957, latest year for which data was reported.

•

PERSONS WITH HEART and blood vessel diseases have been urged to consult their physicians about routine vaccination against influenza.

In a joint statement, the American Heart Association and the National Heart Institute of the U.S. Public Health Service said that "evidence of the past three years abundantly confirmed that dangers of influenza are much greater for patients with heart or lung disease than for others." The risk was described as "particularly high for those with lung congestion due to heart disease."

The association and the federal agency said influenza virus vaccine had been shown "of definite value" in preventing the disease. Side reactions were reported "extremely few."



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Ascorbic Acid (C)	50 mg.
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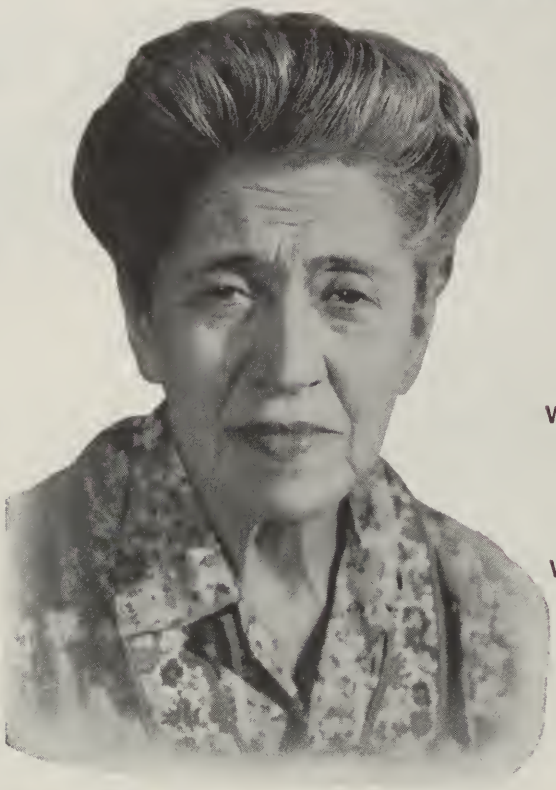
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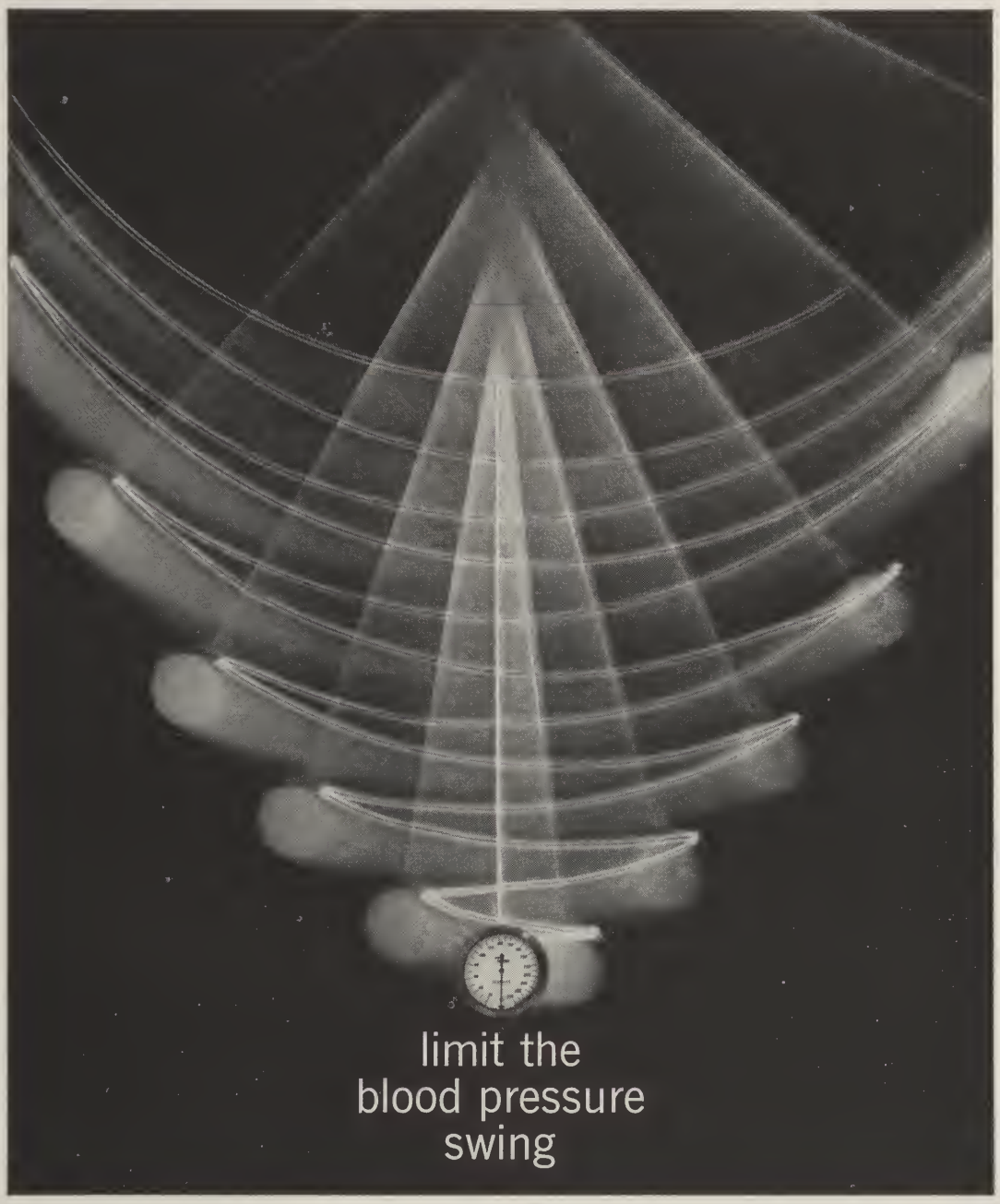
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References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

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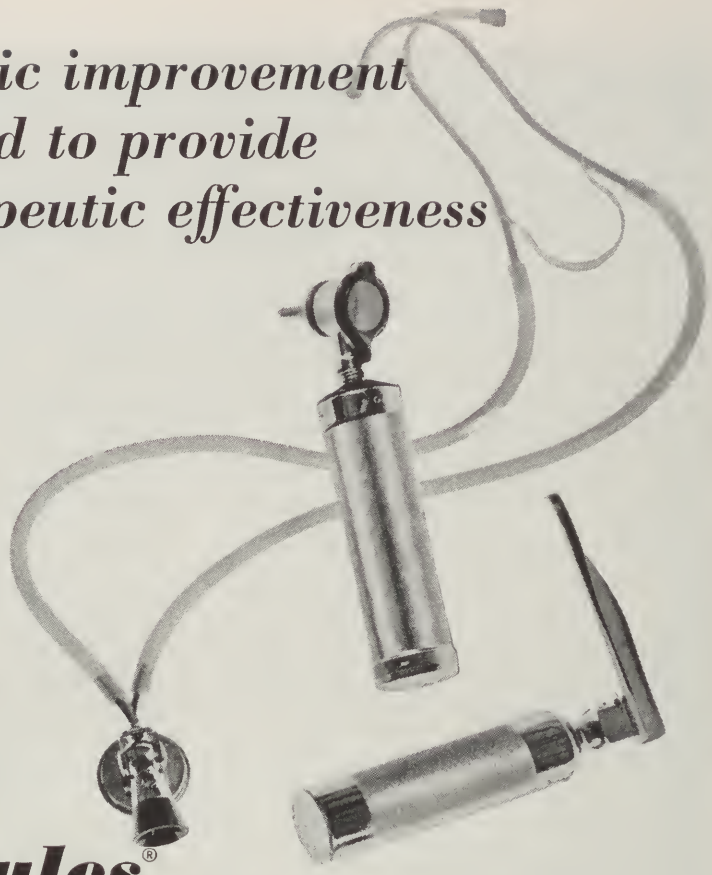
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High Dosage Chemotherapy In Treatment Of 30 Consecutive Cases Of Cavitary Pulmonary Tuberculosis*

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Sputum conversion was obtained in six months in all cases treated with High Isoniazid-Streptomycin combinations. The importance of avoiding treatment failures is emphasized by authors

AT the Arden House Conference held in New York a few months ago, the eradication of tuberculosis was the topic of discussion. It was pointed out that this goal could be reached, if this nation really wanted to reach it. Much emphasis was placed on the proper use of the tools we now have, mainly drug treatment. Dr. Dubos was of the opinion that in a few years it might be too late because of the possibility of increased incidence of drug resistant tuberculosis infections which could not be controlled with our present antimicrobial agents.

Adequate chemotherapy in initial treatment can do much towards the eradication of this disease. It is more than a decade since the introduction of effective agents for the treatment of tuberculosis, and yet there is considerable controversy as to what constitutes adequate chemotherapy. One finds supporters and opponents of a variety of combinations of the principal three drugs, that is, isoniazid, streptomycin and para-aminosalicylic acid.

This study refers to initial chemotherapy, namely that treatment begun as soon as a diagnosis is established. It is becoming more obvious that the most important period of treatment is the first three to six months. On the other hand, there is more uniform agreement in regard to the duration of chemotherapy. For instance, there is agreement that effective chemotherapy should continue for approximately two years following discharge from the hospital. In some cases, as in the "open negative," some investigators recommend continuation of treatment for five years or longer. There is also a trend to use INH more often as a prophylactic measure.

Observations

The discovery of variable rates of inactivation of isoniazid in human beings by Hughes and Schmidt,[1] Bell,[2] Middlebrook,[3] and others, may be considered one of the milestones in

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tuberculosis management. Approximately 35% of the population are considered to be rapid inactivators of INH when given a test dose of 4 to 5 milligrams per/kilo body weight. The level achieved in the serum after six hours in these individuals is less than O.4 micrograms per ml. A percentage of these are very rapid inactivators and their level would fall below 0.2 micrograms per ml. It is thought that racial differences may also play a part with regard to the rate of inactivation of this drug.

Middlebrook[4] has pointed out another important factor, that is, the relationship between catalase activity of tubercle bacilli and isoniazid concentrations. He found that those patients who achieved adequate serum INH levels on a standard dose excreted predominantly catalase negative bacilli. Such patients might remain sputum positive if their second covering drug was inadequate as often happens with the use of intermittent streptomycin. Conversely, those achieving inadequate blood levels on a standard dose excreted persistently catalase positive bacilli.[5] It follows from this that a higher dose of isoniazid would be adequate for a much larger number of patients than the standard 300 milligram dosage. This has been established through serum isoniazid assay techniques.

Role of PAS

Isoniazid is thought to become inactivated through an acetylation mechanism which converts it into acetyl isoniazid. The latter has been found to have no activity against the tubercle bacillus. Thus the most important role of PAS is its competition for the acetylation mechanism, which indirectly produces a higher isoniazid blood level. In rapid inactivators, the addition of PAS helps maintain an adequate serum level of antimicrobially active isoniazid. Other agents, such as barbiturates, tranquilizers and pyridoxine, have no effect on the INH blood level.[6] PAS is also an antituberculous agent but is the weakest of our drugs.

Streptomycin is valuable when used in a dosage of 1 gram daily. However, many physicians disapprove of this dosage because of the danger of toxicity, mainly 8th nerve involvement. In fact, the incidence of such toxicity is not serious enough to make this a deterrent to the use of daily streptomycin. The intermittent use of streptomycin invites drug resistance and therapeutic failure.[7] Isoniazid and streptomycin are bactericidal for rapidly multiplying tubercle bacilli. These two drugs are also readily diffusible into cavities, and isoniazid has been found in adequate quantities in caseous material and other tissue fluids.[6]

Drug resistance has many facets, but the preferred theory today is that a number of bacilli in a large population are found inherently resistant to isoniazid or to streptomycin. Approximately one in 10^6 is thought to be resistant to streptomycin and one in 5×10^4 is thought to be resistant to isoniazid, the latter being more common.[8] It follows, therefore, that adequate therapy with two drugs is essential for optimum results. It is thought that mutants exist which may be inherently resistant to both isoniazid and streptomycin, though these may be very scarce and have not yet been demonstrated. In such instances adequate treatment with three drugs would be indicated.

Material and Method

All original treatment cases, proved to be tuberculous by cultural methods, were accepted for our study irrespective of the stage of their disease. All received streptomycin 1 gram daily and high isoniazid dosage (at least 16 milligrams per/kilo) with small doses of pyridoxine. Sputum conversion was achieved in 100% of these cases before six months' treatment was completed and without the aid of surgical intervention.

Thirty consecutive admissions with cavitary disease were included in this study. These were new cases of tuberculosis, either completely untreated, or having had less than three months' treatment and still excreting drug susceptible tubercle bacilli. The presence of drug susceptible bacilli is of considerable importance since drug resistant infections have been shown to respond very poorly to any form of treatment available.

The diagnosis in each case was confirmed by cultural methods. Twenty-eight patients were classified as far advanced, 23 of these had multiple cavities. Seventy-three per cent had cavities with a maximum diameter of 4 centimeters or greater. Many of these cases had obvious long standing chronic disease previous-

ly undiagnosed, and therefore radiological response in such material could not be expected to be dramatic. Other statistics are seen in Table I.

All cases were started on streptomycin in a dosage of 1 gram daily for three to six months, usually about four months. When treatment was discontinued, that is, after definite evidence of sputum conversion, PAS was substituted. Isoniazid was given in a dosage of about 16 milligrams per kilo, averaging 800 to 900 milligrams daily, with pyridoxine 50 to 100 milligrams daily to prevent toxic neuropathy. In three cases, PAS was added because an initial resistance to INH 0.2 mcg/ml and SM 2 mcg/ml was established, though the bacilli were susceptible to higher concentrations. In 12 cases, pneumoperitoneum was added after 1-3 months of therapy in an attempt to produce more cavity closure. However, in this type of case material, good results from additional pneumoperitoneum have not been numerous. When streptomycin was stopped, high isoniazid and PAS treatment continued for the duration of hospitalization. On discharge, patients were given either isoniazid 300 to 400 milligrams daily and PAS 8 to 12 grams in divided doses; or high isoniazid and pyridoxine alone.

TABLE I

Some Patient Statistics

	Disease Classification		Race		Age		
	FA	MA	W	C	Up to 19	20-39	40+
Male	21	1	20	2	2	6	14
Female	7	1	6	2	2	5	1

This type of therapy in these patients has been well tolerated. Toxic effects were observed in four cases, but in no case was it necessary to discontinue treatment permanently. By and large, high isoniazid dosage combined with pyridoxine presents no serious obstacles. Daily streptomycin for about 3-4 months is tolerated by most patients. This is important because within three to four months one has achieved the desired effect. All but three of these patients were sputum negative by that time. Auditory nerve toxicity of a severe nature is not as frequent as has been believed.

There was one death due to cor pulmonale. He had far advanced disease with a destroyed left lung with multiple cavities, and a spread into the right upper lobe, also with cavitation. He subsequently developed cor pulmonale. His sputum converted in the fourth month of treatment and remained negative by culture for six months before death.

Sputum conversion is taken as the date of the first of a series of negative cultures. 100% conversion has been achieved in our patients by five months of treatment irrespective of the extent of the disease or cavitation, and without surgical intervention, (Table II). This bacterial response has been consistent in all original cases so far, and confirms similar studies by independent groups of investigators.

Patients Ambulatory

Strict bed rest has not been employed with these patients except in the presence of hemorrhage, fever, or severe toxicity. Otherwise, all patients were allowed to be ambulatory on admission, with the observation of an afternoon rest period. This is in keeping with findings at the National Jewish Hospital[9] where it is believed that in ambulatory patients more of the bacilli are in a state of rapid multiplication, and, therefore, readily susceptible to the bactericidal action of streptomycin and isoniazid when given in adequate dosage.

As previously stated, cavity closure has not been too impressive. Marked x-ray clearing was seen in 66% of cases, closure of one or more cavities in 33%. Such a small percentage of cavity closure is attributed to the fact that 22 of these patients had cavities 4 centimeters in maximum diameter or larger. This has been the experience of other authors. Deterioration was not seen in a single case. Figures 1 to 4 show some representative material with the varied roentgenographic appearances encountered in these patients.

A number of patients with residual open cavities have been discharged either because they are poor surgical candidates or because they have refused surgery. All, however, were persistently negative by smear and culture for several months prior to discharge. These will be followed up and studied as open negative cases, and it is hoped that under adequate initial

TABLE II

New Cases Treated At Least Six Months With Daily Streptomycin And High INH

Case #	Dis. Class.	CAVITATION Max. Diam. (cm.)	Number	SPUTUM S	C	Cat.	AFTER TREATMENT X-ray findings Cavity Imp.	Closed	Smaller	Bact. status (months) 1-3	4-6	7-9
1	FA	7.0	Mult.	+	+		Marked		*	—	—	—
2	FA	5.3	Mult.	+	+	++	Marked		*	—	—	—
3	FA	6.0	Mult.	+	+	++	Mod.		*	—	—	—
4	FA	5.5	Mult.	+	+		Mod.		*	—	—	—
5	FA	3.0	Mult.	—	+	++	Marked	*		—	—	—
6	FA	5.0	Mult.	+	+	++	Marked	*	*	—	—	—
7	FA	8.0	Single	+	+	++	Mod.		*	—	—	—
8	FA	5.0	Mult.	+	+	+++	Marked	*		—	—	—
9	FA	9.0	Single	+	+	++	Mod.		*	—	—	—
10	FA	2.0	Mult.	+	+		Mod.	*	*	—	—	—
11	MA	3.0	Single	+	+	++	Mod.		*	—	—	—
12	FA	10.0	Mult.	+	+	++	Mod.			+	—	—
13	MA	2.5	Mult.	+	+	+++	Marked	*	*	—	—	—
14	FA	3.0	Mult.	+	+	+	Marked		*	—	—	—
15	FA	4.5	Mult.	+	+	+++	Marked	*	*	—	—	—
16	FA	6.0	Mult.	+	+	++	Marked	*	*	—	—	
17	FA	11.5	Single	+	+	+++	Marked		*	—	—	
18	FA	9.0	Single	+	+	++	Marked		*	—	—	—
19	FA	2.5	Mult.	+	+	++	Min.		*	—	—	—
20	FA	6.0	Mult.	+	+	++	Marked	*	*	—	—	—
21	FA	5.0	Mult.	+	+	+++	Marked		*	—	—	
22	FA	9.0	Single	+	+	++	Marked		*	+	—	—
23	FA	4.0	Single	+	+	+	Marked		*	—	—	—
24	FA	3.5	Mult.	+	+	++	Mod.		*	—	—	—
25	FA	6.0	Mult.	+	+	++	Marked	*	*	—	—	
26	FA	3.5	Mult.	+	+	++	Marked		*	—	—	
27	FA	7.5	Mult.	+	+	++	Marked	*	*	+	—	—
28	FA	5.0	Mult.	+	+	+++	Mod.		*	—	—	
29	FA	7.5	Mult.	+	+	+	Marked		*	—	—	—
30	FA	7.0	Mult.	+	+	++	Marked		*	—	—	—

Mult.: Multiple cavities
Sing.: Single cavity
S: Smear
C: Culture
Cat.: Catalase Reaction
Dis. . Class.: Disease Classification

Imp.: X-ray Improvement
Bact.: Bacteriology Status
Min.: Minimal
Mod.: Moderate
Max. Diam. (cm.): Maximum Diameter (centimeter)



Figure 1
A 46-year-old white female, admitted with chest X-ray showing three large cavities in the right lung and scattered nodular disease, as well as a spread into the left lung mostly in the upper 2/3, with a cavity in the left upper lobe. Sputum which was positive by smear and culture on admission converted in the fourth month of treatment. X-ray improvement has been marked, with closure of most of the cavities. Patient still in hospital.

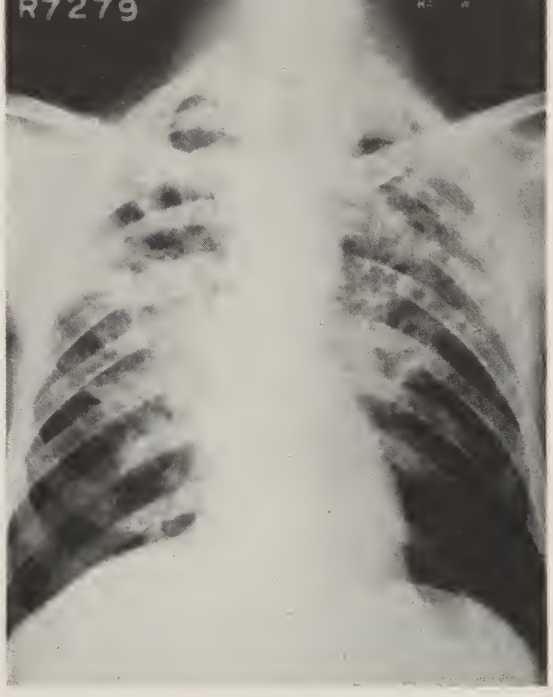


Figure 2
A 43-year-old white male, admitted with far-advanced disease involving mostly both upper lobes with spread into other areas of both lungs. Multiple cavities were present bilaterally. Sputum positive by smear and culture but converted in the second month of therapy. X-ray improvement marked, with closure of some cavities, but others in apices persisted. Surgery not accepted by patient, who was discharged to continue treatment as an out-patient.



Figure 3
A 63-year-old white male with far-advanced disease. X-ray shows a destroyed right upper lobe with a large cavity, and extension of the process to the right lower lung field with further cavitation. The left mid-lung field is also involved in the process with possibly another small cavity, as well as nodular disease in the left upper lobe area. Sputum positive by smear and culture, but converted in the third month of treatment. X-ray improvement marked, with residual cavity in a useless right upper lobe. Surgery not accepted. Patient to continue treatment as out-patient.

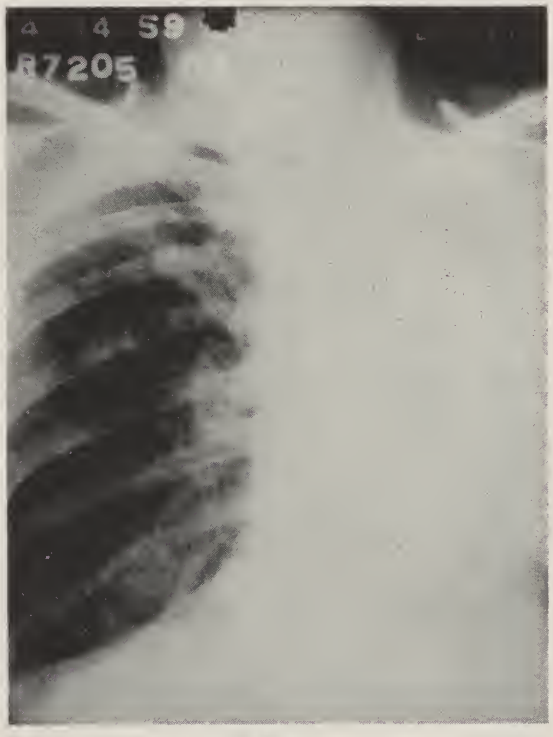


Figure 4
A 53-year-old white male, admitted with roentgenographic appearances of a destroyed, excavated left lung. The disease process also involved the right upper lobe with small cavitation, and infiltration in the lower lung field. Sputum positive by smear and culture on admission but converted in the second month of therapy. X-rays showed moderate improvement. Following several negative sputum cultures, a left pneumonectomy was advised, but patient refused this and left against medical advice.

treatment with high dosage regimens and long term chemotherapy on an out-patient basis, these patients may remain stabilized.

Discussion

Since the introduction of chemotherapy, various therapeutic trials using a large number of combinations have been carried out in different countries. The original trial of the British Medical Research Council recommended daily streptomycin and daily isoniazid as best combination in their hands.[10] Daily streptomycin did not prove too toxic, and, in fact, not as much as large doses of PAS.

Investigators at the National Jewish Hospital have confirmed these findings with the important modification of high isoniazid dosage. Thus, whereas the British trials showed failure to convert in 4% of cases on their daily streptomycin regimen, those from the National Jewish Hospital resulted in over 99% sputum conversion in a series with a follow-up of 2-3 years.

The original Veterans Administration[11] and U.S. Public Health Service[12] trials also included a variety of combinations favoring the use of daily isoniazid and PAS as the treatment of choice. However, originally no study had included daily streptomycin with daily isoniazid. In their series, 15-42% of patients failed to attain a sputum negative status without surgical intervention. Studies by Biehl[13] and the National Jewish Hospital clearly show that intermittent streptomycin, even when combined with high isoniazid dosage, results in many therapeutic failures.

Berte and associates[14] obtained equally good results from treatment with high isoniazid and daily PAS as compared with high isoniazid plus daily streptomycin plus PAS. Their sputum conversion was 99 to 100% in both groups. Nevertheless, they state that there was more radiological clearing in the group getting streptomycin. Toxic reactions were approximately equal.

The results of our high dosage treatment regimen are similar to those obtained by the Denver group. The number of significant toxic reactions encountered is comparable. Critics imply that radiological results are often no better than with conventional dosage therapy—this is not questioned. What is argued, however, is the fact that conventional treatment so extensively used has failed to approach the 100% sputum conversion even after prolonged treatment, let alone after only three to six months of therapy. Many of these failures are found to be resistant to one or more of the three conventional drugs.

On the other hand, in case material such as is presented here where disease is of long duration with much fibrosis, impressive radiological clearing is not to be expected. One might say that one can produce a good chronic case having at least successfully obtained sputum conversion and maintained such a state. On the other hand, if surgery is feasible, this is much better preparation for such intervention. Another study by the Veterans Administration shows only too clearly the shortcomings of conventional therapy.[15] In a group of minimal and moderate non-cavitary cases, failure of the sputum to convert occurred in approximately 5 to 22% of cases within 5 to 8 months of treatment with INH plus PAS, or INH alone. Thus, even in such selected material one does not see 100% sputum conversion and some of their failures were already drug resistant by four months. One wonders, therefore, how much less likely is this type of therapy to attain optimum conversion in case material such as is presented here.

In the National Jewish Hospital study,[16] two cases who left the hospital against medical advice after six months and stopped all chemotherapy were found to have relapsed and were excreting drug resistant bacilli. These were the only relapses recorded in their three-year follow-up.

A further proof of the efficiency of high dosage therapy is the bacteriological study carried out by this hospital on surgical specimens. On the high dosage regimen about 5% positive cultures from resected lesions were recovered,[17] whereas, with conventional previous therapy 139 positive cultures were recovered from a total of 159 (87+ per cent) resected lesions. Other authors have reported 15 to 40% positive cultures recovered from *sputum negative* patients treated with conventional dosage and surgery.

Our bacteriological studies on surgical material are not completed; however, the few so far

examined have been negative by culture. This, in our opinion, emphasizes the supremacy of a combination consisting of adequate dosages of streptomycin and isoniazid in the initial part of treatment. Streptomycin probably need not be continued beyond the three to four month period in most cases. On the other hand, giving it for four to six weeks only is certainly not what one would refer to as "adequate streptomycin therapy."

In a separate study on the retreatment of drug resistant cases we[18] have demonstrated, as has already been done by others, the difficulty of treatment of such cases. We have used high dosages of isoniazid with daily streptomycin or high dosages of isoniazid with daily pyrazinamide and cycloserine. In our small series of cases, failure of the sputum to convert was noted in about 40 to 70% of cases. This poor result following the administration of new antimicrobials has been borne out by several other studies. It throws light on the importance of avoiding failure in initial treatment of tuberculous patients.

We hope that the use of daily streptomycin and high isoniazid dosage may become more widespread. The serious consequences of treatment failure and drug resistance far outweigh the dangers from toxicity of such high dosage combinations. Only when such failures have been eliminated as far as possible, can one say that a major step has been taken towards eradication of tuberculosis.[19]

Summary

The highlights of the Arden House conference are presented, with emphasis on the proper use of chemotherapy. Various methods of conventional therapy are outlined, and the advantages of adequate initial regimens discussed. The use of a high isoniazid-high streptomycin dosage combination is shown to produce a greater percentage of sputum conversion before the emergence of drug resistance, and without surgical intervention.

Thirty consecutive cases of cavitary pulmonary tuberculosis, mostly far advanced, are presented. These were original treatment cases and all received streptomycin 1/gm. daily, isoniazid, usually 16 mg/kilo daily, with pyridoxine 50 to 100mg daily. Sputum conversion was achieved in 100% of cases within six months, and mostly in the first three months. We consider this a much better preparation for surgery in those cases with significant residual lesions. High dosage therapy reported by two other groups has yielded equally good results.

Severe toxic reactions are not frequent enough to be a deterrent to the use of such combinations. On the other hand, this may be an opportunity to avoid treatment failures with drug resistance, hitherto seen fairly frequently in tuberculosis hospitals.

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Chlorothiazide And Related Compounds In The Treatment Of Hypertension

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The thiazide drugs are useful adjuncts in control of hypertension. Increased sodium excretion is a major factor in the therapeutic action. Serious reactions are few and usually mild

CHLOROTHIAZIDE was introduced on the general market in 1958 under the trade name of Diuril® and eagerly welcomed as an effective oral diuretic. It was soon realized that it had also considerable importance in the treatment of hypertension and it is widely used for this purpose.

This paper will outline briefly what is known of the mode of action of this drug, relating this to its intelligent application and, at the same time, pointing out its limitations. Mention will also be made of adverse reactions which have been observed. Three closely related compounds are similar in action, although dosage differs and there is possibly some difference in the incidence of unfavorable side reactions. These drugs are hydrochlorothiazide (Hydrodiuril® and Esidrix®), flumethiazide (Ademol®), and hydroflumethiazide (Saluron®).

Mechanism of Action

The mechanism by which the thiazide drugs reduce elevated blood pressures is not perfectly clear, but there seems to be a definite connection with the diuretic action of the drugs. It has been observed that mercurial diuretics are also capable of reducing elevated blood pressures. Normal blood pressures are not reduced by either thiazide drugs or mercurial diuretics.

Certain events have been observed in association with the administration of one of the thiazide drugs to nonedematous hypertensive or normotensive individuals. As pointed out by Freis[1] and also by Dustan[2] there is a prompt increase in the output of sodium in the urine. Associated with this there is a loss in weight without appreciable change in the concentration in the blood serum of either sodium or chloride. It is postulated that this loss in weight is accounted for by loss of fluid from the extracellular space and that it amounts to from 1 to 2 litres in the first 48 to 72 hours after the drug is started.

Reduction In Plasma Volume

There is also a decrease in plasma volume amounting to about 400 cc. or 15% to 20% of the total. This results in a decrease in right heart pressure and cardiac output. These effects are not temporary, but continue as long as the thiazide drug is given.

If reduction in plasma volume and in cardiac output explains the lowering of blood pressure when thiazide drugs are given, it follows that restoration of plasma volume should bring blood pressure back to its previous level. This result has been accomplished by giving intravenously 500 cc. of 6% salt-free dextran. The same effect can be produced by the administration of salt, but enough must be given to produce weight gain, usually about 25 gm. of salt a day.

Fries[1] points out that a series of events similar to those described above can be produced

From the Medical Section, Lexington Clinic, Lexington, Kentucky. Read April 20, 1960 at 14th Councillor District Meeting, Hazard, Kentucky.

by using a mercurial diuretic such as Mercuhydrin® instead of a thiazide drug. The "rice diet of Kempner" produces similar changes. From these observations one might conclude that the effect of giving one of the thiazide drugs is quite similar to placing the patient on a low sodium diet. Grollman[3] points out that moderate sodium restriction in the diet makes possible satisfactory reduction in blood pressure with small doses of the thiazide drugs. It also follows that the thiazide drugs make available the advantages of sodium restriction without the strict low-sodium diet, a moderate low sodium diet being usually adequate, and much more palatable.

It is not generally conceded, however, that the only action of the thiazide drugs is that which has been described above. Some observers feel that there is some other action, not yet understood, by which the drugs exert a direct influence on blood pressure.

Adjunctive Therapy

As is well known, low sodium diets are much more effective in the reduction of elevated blood pressures if they are supplemented by drugs which are effective in reducing blood pressure. Similarly the thiazide derivatives have a relatively slight effect on hypertension if used alone, but they greatly increase the effectiveness of such drugs as reserpine (Serpasil), hydralazine (Apresoline®) or the ganglion blocking drugs such as pentolinium tartrate (Ansolysen®), mecamylamine (Inversine®), and chlorisondamine (Ecolid®).

It should be recognized that the thiazide drugs are an adjunct to treatment of hypertension and that a satisfactory schedule should usually include one or more of the other drugs considered to be effective in the treatment of elevated blood pressure. In general, the ganglion blocking drugs should be reserved for those patients who have failed to respond to other drugs and who can be kept under careful observation with frequent blood pressure observations in recumbent and standing positions. The thiazide derivatives greatly increase the effectiveness of these drugs and if they are being given along with a ganglion blocking drug, special care is necessary to avoid postural hypotension. The Rauwolfia preparations and hydralazine may, however, be satisfactorily used in office practice and when augmented by one of the thiazide drugs, will often give most satisfactory results.

J. W., a man of 57, illustrates office management of hypertension by the use of these drugs. He was first found to be hypertensive in 1950, with systolic pressures in excess of 200. On reserpine .25 mgm. and hydralazine 25 mgm. four times a day, his pressures were reduced to around 154/92. Hydrochlorothiazide 50 mgm. twice a day was added to the regime and the reserpine and hydralazine was reduced to twice a day. The blood pressure subsequently dropped to 110/80 and he developed minor postural hypotension. The dosage of reserpine and hydralazine was again reduced by half and the hydrochlorothiazide was reduced to 25 mgm. twice a day. On this management his blood pressure varies between 130 and 140 systolic and 80 and 90 diastolic. Attempts to discontinue the drugs have been followed by increases in systolic blood pressures to 180 and above with diastolic pressures above 100.

It is freely conceded that not all patients react so favorably, but this illustrates a general pattern of response in those cases which do not have a fixed hypertension with extensive vascular change or kidney damage.

Post-Sympathectomy Cases

A special area of effectiveness of the thiazide drugs is in those patients who have had a less than ideal response to thoracolumbar sympathectomy or one of the other surgical approaches to the treatment of hypertension. These individuals are especially sensitive to chlorothiazide and related compounds. These drugs must be used with extreme caution to avoid serious postural hypotension, but when thus used they can produce most gratifying results.

J. K. L., a man of 60, is illustrative of the handling of a post-sympathectomy problem. He was first seen in 1947 with blood pressure readings between 200 and 220 systolic and 130 and 140 diastolic. Thoraco-lumbar sympathectomy, according to the technique of Smithwick, was done in July 1947 with a relatively poor initial response, but with eventual leveling off at around 140-170/90-116. Various antihyper-

tensive agents were used with little effect. With the advent of hydrochlorothiazide he was started on 25 mgm. once daily. Systolic pressures at this time were 160-170 with diastolic pressures 100-110. At the next visit his blood pressure was 150/80. The dose was increased to 25 mgm. twice a day. The systolic pressure at the next visit had dropped to 130 and he was experiencing weakness. The dosage was reduced to 25 mgm. daily and he has done well.

Adverse Effects

Toxic reactions to the thiazide drugs have not been common and in general have not been severe. Occasional gastrointestinal disturbances have been reported, but in my experience they have not been a real source of trouble.

Much has been written about electrolyte disturbances, particularly potassium depletion. This seems to be less common with hydrochlorothiazide and hydroflumethiazide than with chlorothiazide and flumethiazide. In my experience, it has been a problem only in those patients who have had a considerable amount of edema and in whom there has been a large diuresis. Potassium deficiency can be readily corrected by giving potassium chloride or potassium triplex. Chloride and sodium deficiencies are less common but can occur. They are usually the result of using too strict a low sodium diet and can be corrected by liberalizing the diet, a form of therapy usually welcomed by the patient.

Precipitation of Gout

It is my custom to allow at least 500 mgm. of sodium a day in the diet. In practice, I usually allow milk and milk products, ordinary bread and permit the food as prepared in the kitchen. I do not allow added salt, foods made with soda, salted or smoked meats, vegetables canned with salt and such foods as salted crackers or salted nuts.

An interesting complication of chlorothiazide therapy is the precipitation of acute attacks of gout in individuals whose gout had previously been under good control. W. M. J., a man of 42 years, was first found to have gout in 1957. In May of 1959 he had a flare-up of gout and was placed on probenecid with good clinical response. In June, 1959, he was given 25 mgm. of hydrochlorothiazide daily because of a mild hypertension. I first saw him on July 30, 1959, in an acute attack of gout. Serum uric acid was 8 mgm.%. The symptoms promptly subsided with colchicine therapy. Hydrochlorothiazide was stopped and he has been free of further symptoms on Anturan.® Warshaw[4] in reviewing this subject postulates that this phenomenon is due to decreased excretion of uric acid by the kidney.

As with many other drugs, occasional skin rashes have been reported due to specific drug allergy. Hoobler[5] reports that he has seen one case of definitely proven chlorothiazide produced thrombocytopenia. Gifford[5] reports one case of thrombocytopenia without purpura and two cases of purpura without thrombocytopenia and one case of anemia in patients receiving chlorothiazide. More serious forms of blood dyscrasias or irreversible blood dyscrasias have not been reported.

Acute Pancreatitis

My colleagues at the Lexington Clinic, D. H. Johnston and A. L. Cornish[6], have reported the occurrence of acute pancreatitis in individuals who had received chlorothiazide over a considerable period of time. In the four patients whom they reported, none of the usual precipitating causes of acute pancreatitis were present. The direct cause and effect relationship has not been proven, but it is strongly suggested.

Further studies are in progress at the Lexington Clinic Foundation by Dr. Cornish. Serum amylase and urinary diastase levels are being evaluated in patients receiving thiazide derivatives. Chlorothiazide is also being fed to experimental animals.

It is still too early to report any results of the study, but if a connection is established between chlorothiazide therapy and acute pancreatitis, this may well be the most serious complication reported so far. When the large number of people treated with chlorothiazide is considered, it must be recognized that this is a rare complication in any case and it should not discourage the use of the drugs when indicated.

Summary

(1) Chlorothiazide and the related products, hydrochlorothiazide, flumethiazide and hydroflumethiazide are useful adjuncts in the treatment of hypertension. Increased excretion of sodium is a major factor in the therapeutic action, although perhaps not the only mode of action.

(2) The thiazide drugs are most valuable when used in conjunction with other hypotensive agents, and potentiate these drugs in much the same manner as the low sodium diet. In office practice the Rauwolfia drugs and hydralazine lend themselves most readily to combination with the thiazide compounds.

(3) The thiazide drugs are particularly effective in individuals who have had thoracolumbar sympathectomy or one of the other surgical approaches to the treatment of hypertension and in those who are receiving one of the ganglion blocking drugs. In these individuals, the thiazide drugs should be used with considerable caution to avoid the development of serious postural hypotension.

(4) Toxic reactions are rare and usually mild. The chief ones are minor skin rashes, gastro-intestinal disturbances, electrolyte disturbances, minor blood dyscrasias and possibly acute pancreatitis. Serious or irreversible blood dyscrasias have not been reported.

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Rationale For Antibiotic Choice*

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Now more than ever, the rudiments of good bacteriologic principles are applicable in treating infectious disease. 'Routine' use of antibiotics in combination is decried

Introduction

THE bedside clinician finds himself in rather strange times. There has been essentially no change in the number or type of bacteria that cause infections, yet in the past 15 years, one has seen an ever-growing spectrum of antibiotic agents to treat diseases. With each morning mail, and from the front and rear of the medical journals, the practitioner is bombarded with advertisements for antibiotics. This literature usually states that by changing the position or the composition of a certain radical, higher and more rapid blood levels will be obtained, or else that an already broad spectrum will become even broader.

Drug company detail men leave literally thousands of dollars worth of antibiotics on our desk tops in hopes that the next patient with a fever will receive his agent (and hence a cure), and that the physician will become "addicted" to this brand name for general use in *all* infections. I intend to review the principles that should guide us in the choice of chemotherapy for a patient sick with bacterial disease.

Bacteria

When we consider bacteria and the choice of antibiotics to eradicate them, we must consider three fundamentals:

(1) What is the bacterium causing the disease?

(2) Is the antibiotic chosen effective against this bacterium?

(3) Can we get blood levels of the antibiotic high enough to be therapeutic?

To isolate and identify the offending bacteria, for the most part, requires a culture. In some cases only a smear and a careful gram stain are necessary. When the patient is desperately ill, we dare not wait for cultures to grow out, and therapy must begin immediately with the most likely effective antibiotic. Subsequently, chemotherapy can be re-evaluated in 24 to 48 hours when the etiological agent is isolated and identified.

Rarely, it becomes crucial to know both genus and species of offending bacteria, so that proper blood levels can be reached. For example, an infection with a group A streptococcus (*S. bovis or S. mitus*) will require just the barest minimum of penicillin, .01 unit per cc blood levels, for eradication. Whereas, the group D streptococcus (Str. liquefaciens or Str. faecalis) will require 3.0-4.0 units of penicillin per cc blood levels and often a companion drug for definite bactericidal action.

Jawetz[1] grouped antibiotics into two categories:

TABLE 1

Group I	Group II
Penicillin	Chloramphenicol
Streptomycin	Tetracycline
Bacitracin	
Neomycin	
Polymyxin B	

Group I is bactericidal in action, and Group II bacteriostatic. As a general rule, a Group I antibiotic will supplement the effect of another Group I, but the administration of a Group II

*Presented at the Fifth District Tuberculosis Hospital at London, Kentucky, on November 20, 1958.

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with a Group I is not advised unless the laboratory evidence (usually tube dilutions) definitely favors the combination.

As of the moment, there are only three unequivocal indications for combination antibiotics. In pulmonary tuberculosis, the combination of streptomycin, I.N.H. and P.A.S. delays the emergence of resistant strains of the mycobacterium. Penicillin and streptomycin together are more effective in the treatment of enterococcal infections (*Str. faecalis and Str. liquefaciens*) than either antibiotic alone. The therapy of acute brucellosis with streptomycin and tetracycline is well founded.

If antibiotics are to be administered in combination, a strong plea is made for their use separately in a tailor-made dose rather than the fixed and often suboptimal ratio of a single capsule or injection. The objections raised by Jawetz[2] to drug combination in a single and fixed form seem valid.

Bacterial Resistance and Sensitivities

One must keep in mind that some bacteria do become resistant to antibiotic exposure after varying lengths of time. Most resistant organisms that appear in the course of treatment represent selection through elimination of sensitive strains rather than the acquisition of resistance by strains that were originally sensitive.[3]

Streptomycin is guilty of having the greatest potential for the development of emergence of resistant varients,[4] and erythromycin is a close runner-up. The eternal battle between the golden staphylococci and penicillin rages on. It now appears that staphylococci that are resistant to 3 units per cc blood levels of penicillin all produce penicillinase and hence may be resistant,[5] and that higher blood levels would be futile. Not so, say other observers and push in 50 to 100 million units of penicillin per day, hoping to overwhelm the micrococci with a bactericidal drug.

All too often do we request that sensitivity studies be set up even before the results of smear or even cultures are known. It seems to me we are not remiss if we wait for the report of a primary smear, before asking the laboratory to set up disc sensitivities. From previous experience we know how certain commonly seen bacteria react to the antimicrobial drugs. The following table is offered as a clinical aid.

TABLE II[6]

Sensitivity Studies Might be Helpful	Sensitivity Studies Usually not Needed
Micrococci	Group A Streptococci
Coliform group	Meningococci
(1) E. Coli	Gonococci
(2) Aerobacter aerogens	Pneumococci
(3) Klebsiella pneumonae	Salmonella
Proteus	Shigella
Pseudomonas aeruginosa	Hemophilus influenza
Bacteroides	P. tularensis
Clostridium	Brucella
	Rickettsia

Only the forewarned and the wary will avoid the pitfalls of antibiotic disc sensitivities, and thence not put undue significance in a disc of impregnated paper lying on a bacteriologic culture. The reader is reminded that the size of the halo around the disc has absolutely no correlation to antibiotic effectiveness, and an antibiotic with a thin rim of clear media around it may be just as efficacious, or even more so, as another antibiotic disc with a far greater clear area. Secondly, and more important, the concentration of the drugs in the discs (that are at present commercially available) is not realistic in that it greatly exceeds obtainable blood levels in vivo.

Antibiotic Blood Levels

The knowledge obtainable of blood levels of each respective antibiotic is often of only academic interest for the clinician whose patient is getting well. But this knowledge becomes less and less esoteric for the patient who has an overwhelming and progressive sepsis and bac-

TABLE III

Chemotheropy	Blood Levels with Conventional Dosage	Blood Levels with Maximal Dosage
Penicillin	1-3 units / cc.	10 units / cc.
Streptomycin	30-40 micrograms / cc.	50 micrograms / cc.
Tetracycline	3-4 micrograms / cc.	5 micrograms / cc.
Chloramphenicol	15-20 micrograms / cc.	50-100 micrograms / cc.

TABLE IV

Guide To Antibiotic Choice

(After T. E. Woodward)

Infectious Agent	SUL	PCN	SM	PM	B	N	C	T	EM	Others
"The Easy Group"										
Group A Strep	2	1					2—	2	2	
Gonococci	2	1					2—	2		
Pneumococcus	2	1					2—	2		
Spirochaeta		1								
"The Diagnostic Group"										
Salmonella typhoea		3					1	3		
Salmonella (other)		3	3				2	3		
Brucella			1 (with T)							
P. tularensis			1				1	1		
P. Pestis			1				1	1		
H. influenza	2		2				1—	1—		
H. pertussis							1—	1—		
K. pneumoniae	2		2				2	2		
N. intracellularis	1	2					1	2		
My. tuberculosis			1 (with INH					3?		
Cl. tetani		2	PAS)				2	1		
Rickettsial							1	1		
Psitticosis (v)								1		
L.G.V. (v)								1		
"The Tough Group"										
E. Coli	2		2			1	1	1 (Kanamycin)		
Proteus	2	2	2			1	1—	1— (Furadantin)		
Bacteroides		2					2	2		
P. pyocyanus			2	1			2	2		
"The Ubiquitous Staph"										
Staphylococci aurea		1	3		2		1—	2	1	Ristocetin Vancomycin Kanamycin Furadantin

1. Drug of choice; very effective.
2. Effective but not uniformly beneficial
3. Slight clinical benefit.

Legend: SUL-Sulfa; PCN-penicillin; SM-streptomycin; PM-polymyxin-B; B-bacitracin; N-neomycin; C-chloramphenicol; T-tetracycline; EM-erythromycin

teriemia or bacterial endocarditis. In such instances, serial tube dilutions combining the offending organism and antibiotic singly or in combination must be set up to determine first what antibiotic (or antibiotics) is needed and next what concentration is required to eradicate bacterial growth.

Table III illustrates the blood levels of the more commonly used antibiotics at conventional and at maximal doses.

Finally, in Table IV we come upon the ground rules for antibiotic choice for specific infectious diseases. The drug of choice that is indicated opposite the specific bacteria is so listed because it has stood the test of time of repeated clinical and laboratory trials. There will be those who violently disagree with the first choice drug as listed, and this is only fitting. In fact, how else could it be, in a situation so variable as infectious diseases where the patient often gets well in spite of drug and doctor.

I believe the blood levels shown illustrate several generally unappreciated facts regarding these four commonly used antibiotics. The degree and rapidity of peak concentration of penicillin vary as to the avenue of its administration. To achieve penicillin serum levels anywhere near 10 units / cc. one must rely upon intravenous administration. Monumental doses of penicillin in ranges of 50 to 100 million units per 24 hours have been used with great success, and one could postulate even higher blood levels yet by this method.

There is probably very little to gain by increasing the dose of streptomycin above one gram per day. Any more than this only en-

hances blood levels by 5-10 per cent, but the dangers of toxicity are multiplied manyfold.

A comparison of chloramphenicol to the tetracyclines would bear mention. One of the beauties of chloromycetin is the possibility of giving up to 5 grams a day with a concomitant rise in serum levels without gastrointestinal symptoms. On the other hand, the tetracyclines in doses of more than 2 grams per 24 hours are frequently attended by the appearance of nausea, vomiting, and diarrhea, yet without significant elevation of blood levels. However, lest the reader finds himself mesmerized by the numbers that represent blood levels, he should remember that there is no evidence yet to prove that just because a certain antibiotic gets a higher concentration in the blood that it is *necessarily* more effective than another agent with lower levels.

The bacteria thus listed are not categorized according to gram stain, bacterial size, or cultural peculiarity. Rather, a division is made according to the problem they present to the clinician. In "The Easy Group" there is no question that penicillin is the drug of choice for these bacteria. Their sensitivity to penicillin has not changed since its introduction for commercial use 16 years ago.

"The Diagnostic Group" is so named because of the sometimes difficult challenge in diagnosis they present to the clinician. Frequently even smear and culture will not give the whole answer; and the second line of diagnostic batteries, the agglutination and complement fixation studies, offer the only chance for an etiological identification.

"The Tough Group" is just that. These bacteria, when present, invariably represent long chronic infection of the genito-urinary tract or else of a draining sinus. A bacterial identification here is simple, but to obtain a bacteriological cure is difficult and taxing.

The problem presented by the ever-present staphylococcus will vary according to where it is seen. In the doctor's office the micrococci are still sensitive to penicillin and a cure is the rule. However, in a hospital practice where the famed 80/81 and the Group III strains of Staphylococci are prevalent and resistant to virtually all of the "first line drugs," an infection by this agent can be life-endangering. Hope for a cure here exists only in optimal drug combination or else one of the newer bactericidal drugs listed.

Summary

The treatment and eventual cure of infectious diseases, now more than ever, require the application of the rudiments of good bacteriologic principles. Rapid and accurate identification of the insulting organism is the preliminary step to the proper choice of an antibiotic. The antibiotic, when chosen, should be administered singly and in adequate dosage to insure effectiveness. The "routine" use of antibiotics in combination is decried except when the laboratory evidence definitely favors a specific combination. Finally, sensitivity tests, although not always needed, are generally helpful. However, one must be alert to the shortcomings and misinformation of paper disc sensitivity tests.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Crushing Thoracic Trauma

Eugene H. Conner, M.D.*

T. W., an 8-year-old white male, was admitted directly to the operating room on 21 October 1959 after having been struck by a motor vehicle. No medical history was obtainable.

Physical Examination

The patient was unconscious but responded to painful stimuli. Skin pale and moist. Skin of face and neck was dusky and showed numerous small petechia. There were superficial abrasions and ecchymoses on the skin of the right anterior chest and upper abdomen which had the appearance of the tread of an automobile tire.

Blood pressure was 128/80 mm Hg., pulse 120-140 per minute and regular. Respirations were labored and there was retraction in the suprasternal notch.

Head: Negative except for petechial hemorrhages in skin and a dusky cyanosis.

Eyes: Pupils round, central and equal. Extraocular movements synchronous; no nystagmus. No bleeding from ears, nose or mouth.

Neck: Showed only distended external jugular veins and the cutaneous petechia and dusky cyanosis already referred to above.

Chest: Diffuse crepitant rales throughout both lung fields. No changes in percussion note. Expansion appeared to lag slightly on the right. No crepitus was felt. Sputum streaked with bright red blood.

Heart: Tachycardia, regular. Mediastinal "click" synchronous with the heart beat. No murmurs.

Abdomen: Rigid and diffusely tender. No bowel sounds. Bloody fluid aspirated from stomach via Levine tube. Bladder apparently intact; clear urine obtained by catheterization.

Extremities: Showed no abnormalities except a few brush burns. Reflexes were considered to be slightly hyperactive.

Hospital Course

The patient promptly received a slow intravenous infusion of 5% dextrose in distilled water after blood was drawn for type and cross match. A tracheostomy was performed over a 24 F. Magill endotracheal tube while the patient was lightly anesthetized with cyclopropane-oxygen. Another 24 F. Magill soft rubber endotracheal tube with inflatable rubber cuff was inserted through the tracheostomy opening and the oro-endotracheal tube removed. Bright red blood mixed with pink froth was aspirated from the tracheobronchial tree.

The patient was observed for 20 minutes while x-rays of the chest, abdomen and pelvis were being made and developed. His condition remained stable during this period, but abdominal rigidity increased. No fractures were observed in x-rays of the pelvis. The chest film showed a fracture of the right 6th rib posteriorly and dislocation of several others on the right and a diffuse haziness in both lung fields,

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but no pneumothorax. On the basis of these findings and the tire tread marks across the right anterior chest wall and upper right quadrant of the abdomen, a laparotomy was performed.

Under light cyclopropane-oxygen anesthesia the abdomen was explored. Free blood found in the peritoneal cavity was observed to be issuing from a stellate laceration of the dome of the right lobe of the liver. The peritoneal cavity was cleared of blood clots, cigarette drains were placed to drain the right subphrenic space and the abdomen was closed.

Throughout the period of anesthesia and operation, the patient was manually ventilated by compression of the rebreathing bag. He tolerated the operation and anesthesia without difficulty, but as a result of his mechanically inefficient thoracic cage, he was unable to breathe adequately during the operation without the assistance of the anesthesiologist.

Mechanical ventilation with the Mörch Piston Respirator (manufactured by V. Müller Company, Chicago) via the tracheostomy tube was immediately instituted at the conclusion of the operation. The patient was hyperventilated and had no respiratory drive of his own. This state of respiratory alkalosis was maintained for six days. During this period of mechanical hyperventilation he maintained an arterial pCO_2 of 22-24 mm Hg (normal 40 mm Hg).

Two complications developed during his post-operative course. First, a right hemo-pneumothorax, which was not radiographically demonstrable immediately following injury, developed during the period of anesthesia and operation. This was treated by a closed thoracotomy connected to water seal drainage. The patient required 750 cc of whole blood in three 250 cc increments to correct for the blood loss from the hemo-pneumothorax. Hemorrhage into the right hemithorax was completely arrested in three days and the thoracotomy tube was removed on the fourth day following injury.

The second complication occurred 24 hours post-operatively when the patient developed a partial obstruction of the airway. This partial obstruction was caused by inspissated secretions, despite the diligent attention of the physicians and nurses to tracheobronchial toilet through the tracheostomy tube. A cast of the trachea and major bronchi was coughed up by the patient and a clear airway reestablished.

The patient otherwise had an uncomplicated clinical course despite a serious injury to the liver, thoracic cage and lungs. He was discharged from the hospital on 9 November 1959, nineteen days following his injury.

Discussion

This patient presents several problems often encountered in the care of the traumatized patient who has an unstable thoracic cage associated with parenchymal damage to the lung.

1. Stabilization of the thoracic cage to restore the mechanical efficiency of respiratory movements.

2. Prevention of airway obstruction by inspissated secretions in patients whose sputum is mixed with blood.

Numerous methods have been devised and employed in an attempt to stabilize the crushed thoracic cage without limiting lung expansion. These employ various traction devices secured to the ribs or sternum. All of these methods suffer from a common fault—the osseous fixation remains unstable and eventually the mechanical attachments to ribs or sternum pull through the tissue and must be replaced. Since this type of injury is becoming more common a more effective form of therapy must be sought.

We have used the Mörch Piston Respirator for the treatment of such injuries in this hospital for over a year and have been pleased with the clinical results of such a method of management. The mechanical ventilator provides adequate ventilation, inhibits spontaneous respiratory movements by maintaining a respiratory alkalosis and an inhibition of respiration via the Hering-Breuer reflex. With the thoracic musculature not contracting to distort an already mechanically disabled thoracic cage and the lungs being actively inflated by the respirator, the thoracic cage can be splinted and rested to facilitate a restoration of normal function.

This method of resting the thoracic cage is based upon sound principles and from a practical standpoint is devoid of the problems and inefficiency of mechano-osseous fixation. The patient is assured of normal oxygenation and free of the hazards attendant to respiratory acidosis.

The inspissation of secretions in the airway is best prevented by the prophylactic instillation of 10-15 cc of physiological saline solution into the trachea each time the tracheal secretions must be aspirated. Aspiration is necessary as often as every fifteen minutes during the first several hours following injury. Instillation of saline solution must be continued as long as there is an admixture of blood present in the secretions, and thereafter if there is thick, tenacious mucous.

Constant vigilance by both physicians and nurses is the key to the prevention of inspissated secretions in the airway. Secretions will tend to dry during mechanical ventilation, for the air that is introduced may be only 50% saturated at room temperature but when warmed to body temperature it is considerably less saturated with water vapor.

Careful observation of the patient for evidence of undue restlessness or agitation, or abrupt change in pulse rate will indicate whether or not the patient on the respirator has developed a partial airway obstruction.

The prompt institution of adequate mechanical ventilation will rest the thoracic cage, insure unimpaired respiratory exchange and assist in restoring in the severely injured patient a normal respiratory mechanism.

Cardiac Output In Response to Surgical Trauma

To obtain a greater understanding of the stress placed upon the circulation by trauma and its relation to the known alterations in endocrine and metabolic activity, observations were made on 45 patients who underwent major pulmonary, cardiac, or abdominal operations. In the normal uncomplicated course a pattern of circulatory response emerged which is divided into a phase of cardiac depression during the anesthesia and operation and a postoperative phase of elevated cardiac output and reduced peripheral arterial resistance. All of the patients showed a depression of cardiac output well below the preoperative basal value after induction of anesthesia which was accompanied by a rise of venous pressure and total peripheral resistance. This was more pronounced during thoracotomy. At the time of endotracheal extubation, a significant elevation of cardiac output occurred. By contrast, all 6 of the patients who failed to exhibit this phenomenon died subsequently. Postoperatively the patients who had laparotomies maintained cardiac outputs at or slightly below their mean preoperative cardiac index of 3.0 L/sq. m/min., while those who underwent thoracotomy sustained an elevated mean cardiac index of 3.5 L/sq. m/min. for a week or more. Although the trauma of major surgery does not place a great demand upon the circulation, inability to meet the basal demands of the tissues for perfusion results in progressive acidosis and death, as illustrated by the courses of 6 patients who died with low postoperative cardiac outputs.

—G. H. A. Clowes, Jr.; L. R. del Guercio and J. Barwinsky—Archives of Surgery (Aug.) 1960.

SPECIAL ARTICLES

The Hospital In Modern Utopia*

RENE J. DUBOS

THROUGHOUT recorded history, dreamers, philosophers and sociologists have imagined all sorts of utopian societies in which everything would be ideally arranged for the health and happiness of mankind. All inventors of Utopias have assumed that disease will decrease in amount and eventually be eliminated altogether as life becomes better organized and the human machine better cared for.

In the modern era, this was the assumption of those who organized the National Health Service in England. In 1942, *The Beveridge Report on Social Insurance and Allied Services* estimated the cost of a comprehensive health service for Great Britain at 170,000,000 pounds and predicted that its development and the consequent reduction in its need would cancel out, leaving the cost unchanged in 1965.

British Press Assurance

Six months after the inception of the program, Mr. Ian Mikardo, M.P., assured his readers in the *Daily Mail* that "the Health and National Insurance Services have settled down and are making us a healthy and unworried (!) people." . . . And indeed, the *Beveridge Report* stated (p.162): "The primary interest of the Ministry of Social Security is. . . . . .in finding a health service which will diminish disease by prevention and cure." As we all know, similar Utopian views of the forthcoming eradication of disease are very widely held in this country today.

I shall base my remarks on a different assumption. Needless to say, I believe that it corresponds to the realities of all types of social structures, not only today but in the future as well. My assumption is that, contrary to the prevalent belief that science and universal medical care will eventually bring about the millennium of health, disease will remain with us. However well organized our life may be and whatever we do to improve the efficiency of our medical and public health programs, the need for medical care will not decrease. What will happen, however, is that the pattern of disease will change with the ways of life, because each type of society and of civilization has disease problems which are peculiar to itself.

The Hospital's Future Role

In the light of this philosophy the hospital of the future can effectively fulfill its role only if it evolves constantly to meet the changing social conditions. It may be appropriate, therefore, to begin the discussion of our topic with a brief statement of the evolution of the hospital in the past and of its place in the world of tomorrow.

Anyone who feels skeptical as to the improvement of the human condition in the course of history might find some solace in the evolution of the hospital concept during the past two thousand years. Originally the Latin word *hospitalis* referred not to an institution concerned with disease, but to a place where a guest was received. And indeed the *hospitalia* during the Middle Ages were essentially guest houses for pilgrims. Then, more and more, hospitals became places where sick and injured poor people were housed, if not cared for, at least to be put away. More frequently than not, going to the hospital was in practice going to a place in

*Address delivered at the dedication of the University of Kentucky Medical Center by Rene J. Dubos of the Rockefeller Institute, New York City, on September 23, 1960.

which to die, for those who did not have the facilities to die more comfortably at home.

In association with the main hospitals, there progressively developed institutions for segregating and housing specialized classes of unfortunates—the lepers, the blind, the aged, the orphans. Then, as the awareness of infection became more prevalent during the 18th Century, these institutions were supplemented by the fever hospitals or pest houses.

All these trends became intensified during the 19th Century, when the Industrial Revolution created immense problems of disease in the destitute proletariat of Europe and the United States. To meet the ever increasing problems of crowd diseases, the hospitals evolved into large municipal institutions which served as refuge for the poor and where the sick went—again chiefly to die. Those economically better situated were taken care of at home.

20th Century Change

The reputation of the hospital improved little by little during the 20th Century. This greater acceptance by the public was due in part to control of hospital infection. It resulted also from the fact that only well-equipped hospitals could provide the required facilities as therapeutic procedures became more effective—but also more complex.

During the first decades of the century, however, only a small percentage of the diseases reached the hospital—chiefly the very serious ones; home care remained the general rule. Then as individual incomes increased, as insurance coverage became more widespread, and furthermore as home facilities became more restricted, an ever larger variety of pathological conditions were directed to the hospital. Today, as we all know, the hospital is no longer a place where poor people go to die. Ideally, it has become the medical center of the whole community, geared not only to treat disease but also to provide general health guidance.

The profound changes that have taken place in the social role of the hospital have resulted in a great enlargement of the opportunities that it offers for medical education.

It is certain, of course, that enterprising physicians and medical students have made use in all historical periods of clinical resources available in hospitals for teaching, learning and research. To illustrate the role of ancient hospitals in the growth of medicine one needs only mention the development of wound surgery in military institutions, the experience on infectious diseases gained in pest houses, the emergence of morbid pathology in general hospitals, etc., etc. But granted these facts, it is apparent nevertheless that until late in the 19th Century most of clinical teaching took place outside the hospital. One of the reasons is that hospital patients were almost exclusively poor people, almost social outcasts, and therefore were regarded as inadequate subjects for teaching because so different socially from the class of patients that physicians saw in their regular practice.

The part of clinical experience then most useful was that corresponding to the ailments seen in the socially well-situated part of the population, an experience that the student could gain only by observing the patients in their own normal environment. Hence the importance of apprenticeship, in which the student learned so much by helping an experienced physician in his practice, acquiring not only medical skills, but also the difficult art of relating the problems of medicine to the circumstances of the physical and human environment characteristic of the normal community. The role of the medical school was then merely to provide dogmatic teaching in the form of systematic background for the practical experience gained by the apprentice at the bedside in the home.

Teaching Responsibilities Increase

In the modern world, as more and more patients are hospitalized, including those with minor illnesses, the teaching responsibilities of the hospital become wider and more critical. The role of the medical school proper, it seems to me, is to teach the permanent basis of knowledge on which scientific medicine is based: the theoretical aspects of human functions, physical and mental; the ecology of human relations; the rational bases of prevention and therapy of disease.

As to the hospital teaching, its role is to reflect the changing aspects of disease as they manifest themselves in a given community at a given time. In other words, the hospital should supplement the universal aspects of medicine which are the main concern of the medical school, by emphasizing the particular problems of health and disease that it has to deal with in order to fulfill its social function.

I shall try to illustrate these statements with

a specific example taken from my own professional specialization, namely, the field of infectious diseases. Clearly it is the responsibility of the medical school to provide a strong theoretical background concerning all types of microorganisms directly or indirectly associated with disease, their pathological manifestation, their vectors and other modes of spread, the normal mechanism of defense of the body, the immological processes, the theoretical bases of therapy. All this material constitutes a body of knowledge of universal and permanent value, that permits the physician to adapt intelligently and rapidly to any kind of special situation that he may encounter in his practice.

In contrast, systematic classroom teaching is ill suited to discuss the specialized problems of infectious diseases as they occur under practical conditions. The difficulty arises from the fact that each community presents a constellation of problems and that this constellation rapidly changes with time. Not so long ago, hospitals were crowded with patients suffering from tuberculosis and other grave infectious diseases which killed children and adults—diarrhea, pneumonias, diphtheria. To a large extent, we know how to prevent or treat these killers of the past, but despite the immense progress of recent decades, all surveys agree in showing that the percentage of patient load due to infection has not decreased, either in hospital wards, or in the community at large. What has happened is that microbial diseases are of a kind different from those of the past.

Ubiquitous Microbes

Most commonly today, problems in infectious pathology come, not from the very virulent pathogens, but rather from the common microbes which are ubiquitous in our environment, and even in our bodies, and which had long been assumed to be essentially harmless. These ubiquitous microbes become agents of disease only when the general resistance of the body has been decreased by disturbances in individual physiology or in social conditions. As is well known, certain surgical procedures, radiation therapy for cancer, the use of certain drugs such as cortisone and even the antibiotics increase the susceptibility of many individuals to infection and thus create a type of disease essentially unknown in the past. Local conditions, such as smogs, may still further complicate the problem of infectious diseases.

These examples will need suffice to illustrate that, while the fundamental principles of medicine are constant, the pattern of disease changes continuously and rapidly. In our present social structure, it is in the hospital that these changes can be most rapidly detected and that the student can best be made aware of the dynamic character of medical problems.

In order to best fulfill its role as a service and teaching institution, the hospital must concern itself not only with the medical problems of its wards but also with those of the whole community that it serves. In the past, as already mentioned, the student acquired his medical experience and began to develop wisdom during his apprentice years. Today, hospital training must substitute for the kind of knowledge that the experienced practitioner was expected to impart to his apprentice.

Social Relations Grow In Importance

But, as we all know, disease as seen in the hospital provides an incomplete and distorted picture of the total health problems in the community. To complete and correct this picture, it is therefore increasingly important that the hospital enlarge its programs in the study and teaching of social relations. Hospital medicine must extend its ministration to the home, both to gain a more accurate estimate of the range as well as relative social importance of the various kinds of medical needs, and to better prepare the young physician for the problems that he will face when he begins functioning in the normal world.

There is another aspect of the physician's role for which the student can be prepared only if he is put in contact early with the problems of the real world. It concerns the relationship between the medical and nursing profession on the one hand, and the other professions which also play a role in the health fields.

Until recent times, the traditional responsibility of medicine consisted almost exclusively in the care of the sick—a highly personal relation between the healer and the individual patient. This role is, of course, as important today as it ever was and modern medical curricula are geared for it. But increasingly and rapidly other problems are arising in our communities which are fundamentally medical, and yet transcend traditional medicine.

As our society becomes technologically more complex and more highly organized, it gener-

ates problems which affect the well being of the social body as a whole—by giving rise to new types of pathological disorders and to new types of collective responsibilities. In this sense, there is rapidly emerging among us a set of problems which could properly be called *social* medicine—and this is not to be confused with *socialized* medicine which is a very different concept.

Whether one likes it or not, the health field is no longer the monopoly of the medical profession, but instead requires the services of all sorts of other skills. This collaboration will become increasingly urgent as the community demands that steps be taken, not only to treat its diseases, but also to protect its health.

Medical Profession Challenged

There is real danger, it seems to me, in the possibility that the medical profession will be progressively edged out of the social aspects of medicine. Persons trained in all fields of physical and social sciences—from engineers to general biologists and to lawyers—have an essential part to play in the total medical picture of our society. But however well trained and wise these specialists may be, it is difficult for persons who have not been trained in the art of medicine to comprehend all the complexities and subtleties of health and disease problems.

There is no doubt, in fact, that medical thought and guidance are needed in many of the important aspects of our technological civilization. Medically trained persons must transcend their preoccupation with disease and begin to concern themselves with the effects of technological and social innovations on normal healthy men. They must learn to collaborate with engineers and sociologists, as well as with politicians, to ward off in so far as it is possible the dangers to health that are inherent in any technological and social change.

Thanks to their greater knowledge of the requirements of the body and soul, the members of the medical profession can help mankind to avoid sacrificing the fundamental requirements of human nature at the altar of dehumanized progress. Thus, I see the ideal hospital not only as a place to treat the sick, but as a center for the appraisal of the human aspects of our mechanical civilization. During our lifetime, hospital medicine will add to its ancient responsibilities in the healing art, a new and essential role in the modern world—namely that of adapting technological civilization to the eternal needs of the human body, and of the human heart.

I began this address by expressing skepticism with regard to the dreams of the Utopians who believe that disease can be eliminated from the world. But I have been guilty of substituting one kind of Utopia for another. What I have done is to present an ideal situation in which the hospital becomes all things to all men in the world of medicine. This Utopian hospital would try to recapture the intimate relationship between physician and patient which is symbolized by the traditional picture of the family physician; it would cultivate the rational approach to disease that has grown out of scientific medicine; it would be a center of social studies where the needs of the body, the aspirations of the soul, and the demands of modern civilization are integrated into a new science of human engineering.

Research Aspects Enlarged

If I seem to have left out the teaching of laboratory and clinical research, it is only because this aspect of the role of the hospital hardly needs to be emphasized nowadays. The availability of public funds for this kind of activity is now assured and makes certain that the modern teaching hospital will increasingly become a research center.

I realize that the wide ranging view of hospital service and education that I have presented here is very far removed from the worldly advice that William Osler gave to young physicians in an address delivered to Army Surgeons on February 28, 1894. Said Osler, "Your business is not to *see* what lies dimly at a distance, but to do what lies clearly at hand." In reality, however, the view that I have tried to convey here is not as incompatible with Osler's teaching as appears at first sight. For what I have described is the kind of atmosphere in which the young physician can be taught to see clearly what lies at hand.

Even if you consider that the picture that I have drawn of teaching in the modern hospital is so Utopian that it will never come to pass, I shall not apologize for having taken you to a land that does not yet exist. Instead, I shall remind you of the fact that in the long run, as Oscar Wilde once said, "Progress is the realization of Utopias."

EDITORIALS

Well Done

IN our opinion the Building Committee of the KSMA for 1959 and 1960 did an outstanding piece of work. Dr. George Brockman of Greenville, chairman; Dr. Lewis Bosworth of Lexington and Dr. Hoyt Gardner of Louisville constituted this committee. The thoroughness with which they gathered information from widely diverse sources, the convincing manner in which they documented this material and placed it before the various smaller groups of the State Society, and their final presentation of their findings and recommendations to the House of Delegates deserve the highest commendation.

It would be unfair to say that this represented the outstanding accomplishment of committee work during 1959 and 1960; many committeemen devoted a great deal of time and skill to their work. It is this combined effort which causes us to move forward from year to year.

The KSMA is to be congratulated upon the ready acceptance of the recommendations of the Building Committee by the House of Delegates. It seems very probable that the establishment of a new home for the Society is a sound and wise proposition financially. It is certain that a fixed base of operation will afford a sense of pride and security which will be stimulating to the over-all effort. It seems reasonable that the increased income of the Society should be, at least in part, directed to some permanent capital improvement. Once established and paid for, this home should yield substantial savings in the operation of our Society.

Every generation of doctors should strive to add something tangible and profitable for the use and guidance of those who are to follow. They who have preceded us have left us as our heritage one of the oldest and finest medical schools in operation, namely, the Medical School of the University of Louisville; a public health system for the state which was developed very early and from which public health activities throughout the world have patterned and profited; a distinguished and dignified pattern of medical practice throughout our state.

Only New York, Pennsylvania, and Illinois have furnished more native sons to the presidency of the AMA than has Kentucky. Two recent past presidents of the American Medical Association who were Kentuckians, Dr. Irvin Abell and Dr. Elmer Henderson, perhaps contributed more leadership in opposition to the socialization of medicine than any other medical statesmen.

Within the past ten years the Kentucky State Medical Association has encouraged the establishment of our new Medical School in Lexington, a facility as efficient and modern in the present era as is the Medical School of the University of Louisville distinguished and steeped in the fine traditions of the past. Under the leadership of our president-elect, Dr. Gaithel Simpson, we have established an indigent medical care program which is one of the first of any state's prepared to benefit by the provisions of the new federal care for the aged. We have this year, by the vote of the House of Delegates, undertaken to establish a permanent home for the State Society.

These are significant accomplishments of our generation looking toward the future. We rejoice in the excellent work of a fine and energetic committee and we congratulate ourselves upon our wisdom in accepting their report.

Sam A. Overstreet, M.D.

Postgraduate Medical Education In Kentucky

THERE is more clincial and basic medical research being conducted at the present time here in the United States and abroad than at any previous time in the history of man. There is reason to believe that this interest and activity in medical research will continue to develop and expand. As a consequence of this research, new information in the field of medicine and health is being made available to physicians in a continuous and growing manner.

The years a physician spends in medical school represent an introduction to the study of medicine. Medical school is only an introduction, as the profession of medicine requires a lifetime commitment of continuous study and self-education. It has become a real problem and a great challenge to the individual physician to keep abreast of new knowledge that he may apply in his particular field of practice.

A physician must take part in postgraduate medical education of some kind if he is going to give his patients the benefit of new medical information and if he is going to have the personal satisfaction that comes from knowing that he is doing a good job in the care of his patients.

The trustees of the KSMA, in their concern about postgraduate medical education, created a special committee to study the entire field of postgraduate medical education in the State of Kentucky. The Committee on Postgraduate Medical Education of the KSMA is made up of members representing all major medical groups within the state and including the two medical schools. This committee, with the approval of the Board of Trustees of KSMA, has created an office for the study and coordination of postgraduate medical activities in the state.

There has been an increasing number of postgraduate programs offered in Kentucky within recent years. In a number of instances, there has been inadvertent duplication of material offered and programs appealing to the same group of physicians have been scheduled on or about the same date. The KSMA Committee on Postgraduate Medical Education hopes that these conflicts in time and purpose may be avoided in the future. Mr. Fred Hertle has been employed as executive director of the postgraduate office. One of his principal duties will be to maintain a master schedule of all postgraduate activities that are going on within the state.

All medical groups, including the two medical schools, have cooperated with the committee in a very excellent manner. As the postgraduate medical education program develops in Kentucky in the years ahead, such cooperation among all groups and all physicians will be essential if the best results are to be achieved.

Walter S. Coe, M.D.

Our Contributors and Advertisers—Thank You

WITH the approach of the Christmas Season, members of the staff of *The Journal* of KSMA, in reflecting on the progress made by it during the past year, wish to express their deep feeling of gratitude to those in two areas that have contributed most to the Journal during 1960.

First, we wish to thank our essayists, our scientific editor and our Board of Consultants for the splendid and unsung contributions they have made. These men, working as individuals and as partners in an unselfish effort to improve the professional skills of our membership and thus better serve the people of our State, can take much pride in their accomplishments.

So that your Journal can be a more potent adjunct in your program of self improvement, Kentucky physicians spend approximately 70 hours each month—financially-uncompensated time. As a result of this effort your Journal is now nationally recognized as being one of the best journals of the small states.

Finally, we want to express our most earnest gratitude for the patronage of our advertisers.

While the staff is constantly seeking to be worthy of the solid backing our advertisers are giving the Journal, we must recognize that without the income from them we could not publish the kind of book we enjoy.

Just as dramatic changes are taking place in the realm of medicine, patterns in the field of advertising are undergoing spectacular revisions in order to lure more of the advertisers' dollar. For example, the use of varying adaptations of AM and FM radio, closed circuit and color televisions are being actively experimented with. The competition for our advertiser dollar is terrific.

Our advertisers are carefully selected. We urge your support of them. In so doing you are not only expressing appreciation for their patronage, you are also showing gratitude for those who provide and present the scientific material and who are dedicated to the goal of constantly improving your Journal.



We Wish You

A Very Pleasant

Holiday Season

Sam A. Overstreet, M.D., Editor
and
The Journal Staff

The Charles H. Todd Memorial Meeting of the Kentucky State Medical Association

Roof Garden, Brown Hotel, Louisville, Kentucky, September, 20-22, 1960
Digest of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Sam A. Overstreet, M.D., Louisville, Speaker of the House, Presiding

First Session

Doctor Overstreet called the meeting to order and asked that Wyatt Norvell, M.D., New Castle, give the invocation. It was reported that a quorum was present by the chairman of the credentials committee, L. F. Beasley, M.D., Franklin. The speaker expressed regret for the absence of Garnett J. Sweeney, M.D., Liberty, vice-speaker of the House, and the hope that the meeting would be carried on with dignity and cooperation. It was moved and seconded that the minutes of the 1959 meeting be accepted as published in The Journal.

The Secretary made the general announcements, stating that the opening ceremonies would begin at 8:45 a.m. Tuesday in the Columbia Auditorium. He announced that the specialty group meetings would be held on Tuesday afternoon and Thursday morning, and that the reference committees would meet in the First Christian Church this year on Tuesday afternoon, also. He urged attendance at the President's Luncheon on Wednesday and announced that meeting places for the Nominating Committee would be designated at the close of this meeting.

At this time, Doctor Troutman read the list of physicians who had died since the 1959 meeting. These physicians, their location, and date of death are as follows:

Abraham, Dallas E., (Emeritus), Louisville, October 22, 1959
Beckett, Austin L., Lexington, September 10, 1959
Bell, Joseph C., (Member), Louisville, April 25, 1960
Blodgett, Jean G., Louisville, October 26, 1959
Branaman, E. L., Taylorsville, January 3, 1960
Cook, Oliver C., Marion, July 31, 1960
Davidson, Andrew J., (Member), Prestonsburg, July 1960
Dorger, Philip H., Covington, September 18, 1959
Dunham, Elgin S., (Member), Edmonton, November 27, 1959
Estridge, Floyd, (Member), Lancaster, April 30, 1960
Faulkner, Morton, (Emeritus), Mt. Sterling, July 15, 1960
Gibson, C. V., Science Hill, September 27, 1959
Gingles, Hunter W., (Emeritus), Bowling Green, February 5, 1960
Goodman, Arthur O., (Member), Louisville, January 16, 1960.
Goodpaster, J. Scott, Owingsville, February 20, 1960
Griffith, D. M., (Emeritus), Owensboro, October 9, 1959
Harned, E. C., Louisville, March 25, 1960
Harvey, John, Jr., Lexington, November 14, 1959
Henson, Sam L., (Member), Benton, November 1, 1959
Hermann, Edward, Newport, December 10, 1959
Hopper, Walter O., (Emeritus), Perryville, December 5, 1959
Hume, Omer F., (Member), Richmond, October 30, 1959
Jansen, Verna May, Ashland, July 6, 1960
Johnson, Wm. O., (Member), Louisville, February 5, 1960
Johnston, M. E., (Emeritus), Lexington, March 5, 1960
Keeney, Palmer G., Bellevue, October 14, 1959
Kennedy, E. L., (Member), Smithland, October 6, 1959
Kercheval, Clarence K., Ashland, February 13, 1960
Lattimore, J. A. C., (Col.), Louisville, December 31, 1959
Leachman, George C., Louisville, June 26, 1960
Lee, Insun, (Member), Louisville, March 19, 1960
Linton, Frank T., (Member), Princeton, November 2, 1959
Logan, Leslie, (Emeritus), Barbourville, April 1, 1960
Mathewsian, Mehron H., Louisville, April 11, 1960
McMillen, C. F., Covington, February 21, 1960
McWilliams, Wiley E., Lexington, November 11, 1959
Meyer, J. Harold, (Member), Louisville, July 18, 1960
Miller, Eunice W., (Member), Hazel, December 9, 1959
Moss, Thomas E., Woodville, July 26, 1960
Muncy, Paul E., (Member), So. Ft. Mitchell, February 15, 1960
Nicholas, C. L., (Emeritus), Louisville, November 10, 1959
Pakalins, Alfreds, Hazelwood, January 13, 1960
Petty, Carlisle R., (Member), Louisville, October 26, 1959
Ragan, David Y., Cold Springs, April 13, 1960
Rice, William H., (Member), Ashland, July 5, 1960
Richardson, Cleves, (Emeritus), Louisville, April 20, 1960
Richardson, J. L., Ashland, March 23, 1960
Rogers, John C., (Member), Henderson, January 31, 1960
Schwertman, A. J., (Member), Covington, July 23, 1960
Sights, Warren P., (Emeritus), Paducah, May 18, 1960

Smith, Frank H., (Member), Paint Lick, October 5, 1959
Smith, Robert W., (Member), Owensboro, December 16, 1959
Stewart, Herbert B., (Emeritus), Morganfield, July 31, 1960
Trimble, V. G., Somerset, October 9, 1959
Wallin, William B., (Member), Brooksville, December 16, 1959
Weddle, Achilles, (Member), Somerset, April 11, 1960
Webb, G. P., (Member), Burning Springs, April 7, 1960
Williams, John H., (Col), Louisville, December 6, 1959
Witherspoon, E. O., (Emeritus), Louisville, January 3, 1960
Zimmerman, Francis B., Louisville, September, 1959
Zurcher, Clarence H., Louisville, July 21, 1960

After the list of deceased physicians had been read, the House stood for a moment of silent tribute to these men.

The Speaker announced the reference committee appointments, subject to the approval of the House of Delegates, as follows:

Reference Committee No. 1—Reports of Officers and Councilors

Carl H. Fortune, M.D., Lexington, Chairman
Bruce Hamilton, M.D., Shepherdsville
W. R. Houston, M.D., Erlanger
L. P. Moore, M.D., Owensboro
Guy Cunningham, M.D., Ashland

Reference Committee No. 2—Reports on Medical Care, Medical Education, Hospitals, and Related Subjects

B. J. Baute, M.D., Lebanon, Chairman
Kenneth Crawford, M.D., Louisville
Harold Eskind, M.D., Louisville
D. L. Graves, M.D., Frenchburg
Thurman Perry, M.D., Jenkins

Reference Committee No. 3—Reports on Legislation and Public Relations

Loman C. Trover, M.D., Madisonville, Chairman
Joe Bush, M.D., Mt. Sterling
J. D. Handley, M.D., Hodgenville
Alfred O. Miller, M.D., Louisville
Ruel T. Routt, M.D., Sonora

Reference Committee No. 4—Reports on Miscellaneous Business

Robert L. McClendon, M.D., Louisville, Chairman
H. F. Chambers, M.D., Campbellsville
C. D. Snyder, M.D., Hazard
John Sonne, M.D., Bardstown
Dave H. Thurman, M.D., Louisville

Reference Committee No. 5—Reports on Miscellaneous Business

O. Leon Higdon, M.D., Paducah, Chairman
Austin Bloch, M.D., Louisville
D. M. Greeley, M.D., Harlan
R. L. Shuffett, M.D., Greensburg
E. C. Strode, M.D., Lexington

Reference Committee No. 6—Reports on Miscellaneous Business

Carl Cooper, M.D., Bedford, Chairman
Howard I. Frisbie, M.D., Stanford
Nathan I. Handelman, M.D., Louisville
Robert Houston, M.D., Eminence
M. C. Loy, M.D., Columbia

Reference Committee No. 7—Reports on Miscellaneous Business

Benjamin Boone, M.D., Louisville, Chairman
Elias Futrell, M.D., Cadiz
Douglas Jenkins, M.D., Richmond
W. K. Skaggs, M.D., Taylorsville
Robert S. Tillett, M.D., Louisville

Motion was made and seconded that the reference committee appointments as made by the Speaker of the House be accepted. Motion carried.

The reports of the officers and committees were presented at this time and referred by the Speaker to the respective reference committees as follows:

Report of the President—Reference Committee No. 1

Report of the President-Elect—Reference Committee No. 1

Report of the Speaker of the House—Reference Committee No. 1

Report of the Chairman of the Council—Reference Committee No. 1

William H. Bizot, M.D., Chairman of the Awards Committee, presented the committee's nomination as follows:

Distinguished Service Award—George P. Archer, M.D., Prestonsburg

Outstanding General Practitioner—John B. Rypstra, M.D., Annville

Motions were duly made, seconded and carried that Doctor Archer be presented the Distinguished Service Award and that Doctor Rypstra be presented the Outstanding General Practitioner Award.

Other reports were received and referred as follows:

Report of the Secretary—Reference Committee No. 1

Report of the Editor—Reference Committee No. 1

Report of the Treasurer—Reference Committee No. 1

Report of the Delegates to AMA—Reference Committee No. 1

Report of the Executive Secretary—Reference Committee No. 1

It was explained at this time that the chairman of the Committee to Study the Constitution and Bylaws, Doctor Combs, could not be present to present his committee's report. The Association's attorney, Mr. Davis, was asked to do this. At this time, motion was duly made, seconded, and carried that, since this report was very long, the attorney cover the highlights and that the members of the House be given ample opportunity to ask questions.

Mr. Davis explained that the House of Delegates had authorized the bylaws committee to revamp the Association's committee structure with the view of making it more effective. He explained that the Committee to Study the Constitution and Bylaws was ready to report at the 1959 session, but due to certain changes that would be necessary to make in the constitution before the changes could be implemented, the bylaws conmittee had recommended to the 1959 House of Delegates that the constitution be changed first.

Mr. Davis reminded the House of Delegates that it is necessary for any changes in the constitution to be proposed one year and voted on the next year. He pointed out that the proposed changes the bylaws committee submitted in 1959 had been given the tentative approval of the House, that the changes had been mailed out two months prior to this meeting as provided by the constitution, and suggested that it would make the work of the reference committee easier if the House could see fit to accept the constitutional changes as proposed at this time. Following

discussion of this suggestion and the proposed changes, it was moved and seconded that the constitution be unanimously approved as mailed to each of the county societies and delegates and as approved at the 1959 meeting of the House of Delegates. The motion carried.

Mr. Davis then went through the proposed bylaw changes, giving special attention to the major revisions and answering questions that were asked. Following this, the speaker urged the delegates to study this matter carefully before final action on a revision of the bylaws was taken on Wednesday night, September 21.

After these comments and explanations, the Speaker referred the report of the Committee to Study the Constitution and Bylaws to Reference Committee No. 4.

Benevolt Fund Committee—Reference Committee No. 4

Committee on Medical Education and Economics —Reference Committee No. 2

Medico-Legal Administrator — Reference Committee No. 5

Advisory Committee to the Editor—Reference Committee No. 6

Committee on Public Information and Service—Reference Committee No. 3

Committee on Physicians Placement Service—Reference Committee No. 7

Committee on Legislation—Reference Committee No. 3

Committee on Third Party Medicine—Reference Committee No. 3

Medicare Review Committee — Reference Committee No. 2

KSMA Advisory Committee to the U. of K.—Reference Committee No. 2

Committee to Study New Home—Reference Committee No. 1

KSMA Advisory Commission to Blue Shield—Reference Committee No. 5

Committee on Scientific Assembly and Arrangements—Reference Committee No. 2

Committee on Emergency Medical Services—Reference Committee No. 6

KSMA Liaison Committee to Voluntary Health Groups—Reference Committee No. 5

McDowell Home Committee— Reference Committee No. 3

Committee on Rural Health — Reference Committee No. 5

Advisory Committee to Woman's Auxiliary—Reference Committee No. 6

Committee on Medical Services—Reference Committee No. 6

Committee on Allied Professions—Reference Committee No. 2

KSMA Representative to Conference of Presidents and Other Officers of State Medical Associations—Reference Committee No. 5

KSMA Representative on Joint Commission for Improvement of Patient Care—Reference Committee No. 7

KSMA Advisor to University of Louisville Student AMA Chapter—Reference Committee No. 6

KSMA Representative on State Practical Nurses Advisory Committee—Reference Committee No. 7

KSMA Representative on State T.B. Coordinating Council—Reference Committee No. 7

Board of Directors of the Kentucky Physicians Mutual, Inc.—Reference Committee No. 5

Rural Kentucky Medical Scholarship Fund—Reference Committee No. 7

Advisory Committee to Selective Service—Reference Committee No. 4

Professional Relations Committee—Reference Committee No. 2

Report of the Woman's Auxiliary— Reference Committee No. 6

Representative on Advisory Committee on Maternal and Child Health, of the Department of Health—Reference Committee No. 7

Kentucky Health Council—Reference Committee No. 5

Kentucky Public Health Association Liaison Representative—Reference Committee No. 6

New Business

The new business was then presented to the House and referred to reference committees by the Speaker, as follows:

(A) Resolution of the KSMA Council pertaining to the calling of a constitutional convention—Reference Committee No. 3

(B) Resolution of the KSMA Council concerning the practice of mail order drugs—Reference Committee No. 3

(C) Resolution of the Committee on Medical Education and Economics relating to obtaining a congressional hearing on veterans affairs—Reference Committee No. 2

(D) Resolution of the Committee on Medical Education and Economics urging strict screening of non-service connected disability veterans admitted to government hospitals—Reference Committee No. 2

(E) Resolution of the Jefferson County Medical Society supporting the limited constitutional convention and the Better Roads and Parks Bond—Reference Committee No. 3

Doctor Overstreet then designated meeting places for the Nominating Committee for General Officers and the six Councilor Districts Nominating Committees to be held immediately at the close of the session. He announced that the Nominating Committee would make known its recommendations for the various state offices on Tuesday morning at the close of the first scientific session. Doctor Overstreet reminded the members of the House that additional nominations could be made from the floor on Wednesday night after the nominations of the above committees had been read.

The Speaker expressed appreciation to the members of the House for their attention and cooperation.

There being no further business, a motion was duly made, seconded and carried that the meeting adjourn at 10:05 p.m.

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Second Session

The second session of the Kentucky State Medical Association House of Delegates was called to order on Wednesday, September 21, 1960, by the speaker, Sam A. Overstreet, M.D., in the Roof Garden of the Brown Hotel, Louisville at 7:10 p.m. The invocation was given by David M. Cox, M.D., after which the credentials committee reported a quorum present.

The Chairman of the Board of Trustees,

Carlisle Morse, M.D., presented the final report of the Board as follows:

The Board submitted the following resolution passed at its September 21 meeting:

WHEREAS the 1960 Annual Meeting has been a substantial success; and

WHEREAS the Committee on Scientific Assembly and Arrangements, thirteen cooperating specialty groups, guest speakers, and scientific exhibitors have cooperated in presenting an outstanding scientific program; and

WHEREAS the Smith Kline & French Laboratories, at considerable expense, chose this Association to present the first transatlantic broadcast at a state medical association meeting, which was a very interesting and profitable program; and

WHEREAS the technical exhibitors, the Brown Hotel, the Columbia Auditorium, along with all the other organizations, agencies, and individuals have cooperated in making this meeting successful, now therefore be it

RESOLVED, that this House of Delegates go on record as expressing its deep appreciation to all who have had a part in the development, implementation, and presentation of this meeting.

Mr. Speaker, I move the adoption of this resolution. The motion was duly seconded and carried.

The reports of the reference committees were then presented.

REFERENCE COMMITTEE NO. 1

Carl Fortune, M.D., Chairman
Reports of Officers and Councilors

The Report of the President

During the past year your president has attended 48 meetings: those of the Executive Committee of the Council, of the Council, of the Councilor Districts, of the Allied Medical groups, of the Annual Meetings of surrounding states, of regional meetings of the AMA, of the AMA and those in Frankfort and Washington dealing with legislative matters.

A special effort has been made to assure our four allied medical groups that their problems belong to us and that we, all of us, must be firmly united in dealing with the political problems now existing in Frankfort and Washington. Divide and conquer has been a device effectively employed in every field of endeavor. It could at this time permanently alter the pattern of medical care enjoyed by the American people.

While attending the Annual Meetings of surrounding states, a sincere and firm attempt was undertaken to gain the good will of as many officers as possible and to inform them that our organization is actively participating in everything that is going on anywhere on any level.

At the Regional and National Meetings of the AMA a similar plan was effected to convince the officers of the AMA and their representatives from the home office in Chicago that our group was both present and working. Indeed, they now know that thoughts and ideas presented at these meetings have been developed into active programs of the KSMA. The liaison between Chicago and Louisville is currently one of confidence and strength.

The numerous conferences in Frankfort and Washington have created personal friendships which permits of confidential exchanges of ideas. In both areas our relations are open and warm. To be perused in the personal file of the President, located in the office of KSMA, are 62 letters which convince at least one member of this organization that such communications are both necessary and invaluable.

During the last meeting of the General Assembly this organization watched the five bills in which it was interested passed and signed into law. This was achieved through the untiring work of one group and two individuals. The Legislative Committee, George Archer, M.D., Prestonsburg, being chairman for national affairs, and Wyatt Norvell, M.D., New Castle, chairman for state affairs, met in fair weather and foul and both by night and day. Even so, they could not remain in Frankfort for sixty days and so could not become acquainted with the legislators. Dr. Mitchell Denham, a member of the House of Representatives, did reside there but his position was always open to attack on the basis of special and selfish interests. Mr. Bobbie R. Grogan did stay in Frankfort as our Registered Lobbyist. As such, he furnished that priceless part of the effort which no one else could. We were well represented by skilled people who knew where they were and what they were doing.

Fourteen members of this organization donated of their time, effort, and funds to escort their wives to our dinner given at the Mayflower Hotel during February for our Congressmen and Senators and their wives. This purely social affair, where there is no protocol, no speeches, and no politics, is enjoyed and attended by all of our legislators. It must be admitted that for one and one-half days these same 14 men had been calling on these same legislators in their offices, where matters of mutual interest could be discussed in private. This Washington visit must be continued, for it creates the acquaintances and the atmosphere which makes all else possible.

Many members of this organization have unselfishly and freely donated their time, energy and funds to attend different ones of these meetings when requested to do so. It must be realized that whatever has been accomplished has resulted, not from the efforts of one member, but of many members. In my humble judgment, this organization has, during this year, been represented by a superb team of many members.

Irvin Abell, Jr., M.D., Louisville
President

Recommendations, Reference Committee No. 1

The report of the President to the 1960 House of Delegates was carefully considered. Your Committee is much impressed with the excellent work which has been done by Irvin Abell, Jr., M.D., president for the past year, and with the large amount of effort which he has put forth on behalf of the Association. We recommend that the House of Delegates accept his report and in so doing that they express the heartfelt thanks of the KSMA for his valuable service.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Meetings Attended by the KSMA President on Behalf Of the Association During the 1959-60 Year

1959

Oct. St. Louis—Legislative
Relative Value Study—Indianapolis
Meeting with candidates for Governor
Indiana State Medical meeting
Executive Committee
Cleveland—On aging
Kentucky Association of Registered Nurses

Nov. Legislative Committee—Lexington
Committee on Scientific Assembly and Arrangements

Dec. McDowell Stamp celebration—Danville
Allied Council on Medical Services meeting
KSMA Council

1960

Jan. State Medical Technicians—annual meeting
Legislative Committee — Black Angus—Shelbyville

Feb. Washington Dinner for Congressmen
Blue Shield—Lane Tynes—Chicago
Legislative Committee—Frankfort

Mar. Executive Committee
Council of KSMA
Officers Conference
Outwood meeting

April Kentucky Dental Association
8th District at Covington
9th and 11th District—Paris
14th District—Hazard
15th District—Ashland
Tennessee State Medical meeting—Nashville

May 12-15 District—Cumberland Falls
Ohio State Medical—Cleveland
Illinois State Medical—Chicago
7th District—Frankfort
2nd District—Owensboro
KAGP—Louisville
Kentucky Hospital Association—Louisville

June 4th and 6th District—Mammoth Cave
AMA—Miami, Florida
Executive Committee
To Washington on Mills Bill

July Constitutional Convention—Frankfort
Council Meeting
Public Hearing on Constitutional Convention —Frankfort
Kentucky Pharmacy meeting—French Lick

Aug. AMA Legislative meeting—French Lick
West Virginia State Medical meeting—White Sulphur Springs
Regional Meeting, KAGP—Lexington
1st, 3rd Councilor Districts—Ken Lake

Sept. Public Relations: AMA—Chicago

Report of the President-Elect

Since the 1959 meeting of the Kentucky State Medical Association, I have continued to attend the meetings of the Council, the Executive Committee and other special committees. This has kept before me the continuity of the work of KSMA, the problems which have been solved in the past year and the problems which will face us in the next. I have had political information and public relations publications regularly from the AMA, the study of which has been most informative and instructive. The future of medicine as we know it is becoming more uncertain daily. Certainly both fields will be prominent in our efforts during the next year. In August I attended a conference sponsored by the Council of Legislative Activities of the AMA at French Lick, Indiana. This meeting emphasized the fact that we must be practicing citizens as well as practicing physicians.

This has been a good year for me and with the help of my friends and colleagues in the Council, the committees, and the home office, I know that the next year will be an equally successful one.

Richard G. Elliott, M.D., Lexington
President-Elect
Kentucky State Medical Association

Recommendations, Reference Committee No. 1

Mr. Chairman, the Committee has considered the report of the President-elect, Richard G. Elliott, M.D. and wishes to express appreciation of his activity in acquainting himself with the affairs of the KSMA. In accepting this report, we recommend that the KSMA express appreciation for his excellent services during the past year and wish him well during the term of his presidency.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the Speaker

During the 1959 meeting of the Kentucky State Medical Association the House of Delegates nominated me for position of Speaker of House for the ensuing year. From that time until now I have undertaken to keep myself as well informed as possible regarding the current issues involving the Association to the end that affairs of the House may be conducted as expeditiously and profitably as possible during the 1960 session.

I appreciate the high honor conferred upon me by your body and assure you that I shall make every effort to discharge my duties faithfully.

Sam A. Overstreet, M.D.
Speaker of the House of Delegates
Kentucky State Medical Association

Recommendations, Reference Committee No. 1

The Committee recommends that in adopting this report, the Association express appreciation to Sam A. Overstreet, M.D., for the efficient way in which he has discharged the arduous duties as Speaker of the House. Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Report of the Council

During the past associational year, at the time this report was written, the Council had held a reorganizational meeting, three day-long meetings, and one five-hour meeting. In addition, the Executive Committee of the Council had held three day-long meetings. As both the Council and the Executive Committee meetings are unusually well attended, this will give you an excellent idea of the amount of time and effort that your officers and members of the Council are expending each year in carrying on your Association's work.

You will recognize, of course, that it is not possible in the time allotted for this report to begin to cover in detail all of the actions taken by the Council and its Executive Committee during the year. If, however, any member of the Association is interested in reading the full minutes of the Council or the Executive Committee or any part of them, the member is invited to do so at the Headquarters Office of the Association.

Matters of prime concern to members of the Council during the past year included legislative affairs, both at the national and state levels, the passage of the Indigent Care Program and its successful opera-

tion, third-party problems, along with routine matters. High lights of the actions of meetings held by the Council during the 1959-60 associational year follow. The level of attendance at meetings of both the Council and the Executive Committee of the Council during this associational year has been very high. Interest and cooperation of the members are most appreciated.

FIRST MEETING—The organizational meeting of the new Council for the 1959-60 associational year was held Thursday, September 24, at the Brown Hotel during the last meeting. The Council was called to order by the temporary chairman, Carlisle Morse, M.D., Louisville.

The first order of business was the election of a permanent chairman and Doctor Morse was unanimously elected without opposition.

Special recognition was given Richard G. Elliott. M.D., Lexington, who had been serving as Councilor from the Tenth District and who was elevated to the office of President-Elect.

New members of the Council were then recognized. They were: David M. Cox, M.D., Louisville, vice-president (central); W. O. Preston, M.D., Lexington, vice-president (eastern); and Rex E. Hayes, M.D., Glasgow, (western); Sam A. Overstreet, M.D., Louisville, Speaker of the House; Hugh Houston, M.D., Murray, new Councilor from the First District; Dixie E. Snider, M.D., Springfield, new Councilor for the Fourth District; William C. Hambley, M.D., new Councilor from the Fourteenth District.

In addition, Doctor Morse welcomed back Garnett J. Sweeney, M.D., as Vice Speaker of the House of Delegates, who had recently completed two terms with the Council; Vinson Pierce, M.D., who was re-elected as delegate to the AMA; Ralph Lynn, M.D., re-elected to serve his second term as Councilor from the Third District; along with Thomas O. Meredith, M.D., Harrodsburg, who last year was a vice-president and this year elected as Councilor for the Twelfth District.

The office of vice-chairman was then filled when James M. Stevenson, M.D., Brooksville, Councilor from the Ninth District, was elected to that office.

The next order of business was forming the Executive Committee of the Council, which is composed of the Chairman of the Council, Vice-Chairman, President, President-Elect, Secretary, and two Councilors which were to be elected at that time. Norman Adair, M.D., Covington, Councilor for the Eighth District, and John Pepper Glenn, M.D., Russellville, Councilor for the Sixth District, were elected to fill out the personnel of the Executive Committee.

Wyatt Norvell, M.D., New Castle, was elected as Chairman of the KSMA Legislative Committee for State Affairs, and George Archer, M.D., Prestonsburg, was elected Chairman of the KSMA Legislative Committee for National Affairs.

An invitation from the AMA's Council on Legislative Activities relative to a forthcoming national legislative conference at St. Louis, October 2 and 3, was read. It was decided that the KSMA President, Chairman of the Council, Legislative Chairmen, and Executive Secretary should attend this meeting. It was also decided that the KSMA's third congressional dinner honoring Kentucky's senators and congressmen be held Thursday, February 25.

The Council voted to extend to George W. Pedigo, M.D., an invitation to attend all meetings of the Council, in order that he might have more information on the Association's activities which would be useful to him as a member of the Board of Directors of the Kentucky Chamber of Commerce.

Inasmuch as Doctor Elliott had been elevated to the office of President-Elect and a vacancy existed in the Tenth District where Doctor Elliott had been serving as Councilor, the Council proceeded to authorize the mechanics for an interim appointee, as provided by the Bylaws, to serve until the 1960 meeting of the House of Delegates when a new Councilor would be elected to fill out the term, which would expire in September, 1961.

SECOND MEETING—The Council held its second meeting in the Brown Hotel on December 17, 1959.

The first order of business was the filling of a vacancy on the Council from the Tenth Councilor District—occasioned by the election of the incumbent Councilor Richard G. Elliott, M.D., as President-Elect. In compliance with the Bylaws, the name of Douglas E. Scott, M.D., Lexington, was presented as a nominee from the delegates of that district to serve as councilor until the next meeting of the House of Delegates. His election was unanimous.

The President, the Secretary, and the AMA Delegate gave their reports in that order. (For a written report of the AMA Delegate of the interim meeting in Dallas on December 1-4, see Page 205 of the February, 1960, Journal of KSMA.)

The Council then considered and adopted two recommendations of the KSMA Committee on Scientific Assembly and Arrangements. The first recommendation called for changing the meeting place of the reference committees, Tuesday afternoon, September 20, during the 1960 Annual Meeting, from the basement of the Columbia Auditorium to the air-conditioned Sunday School building of the First Christian Church adjacent to the Auditorium. The second recommendation asked that no meetings be held on Wednesday, the second day of the Annual Meeting, that would conflict with the KSMA President's Luncheon or the important House of Delegates final session which begins with a dinner meeting that evening. The Council agreed to support the University of Louisville Alumni Association if a luncheon or dinner is planned on Thursday during the Annual Meeting.

The Council authorized the mailing of a letter to all members of KSMA over the signature of the president and chairman of the Council as voted by the House of Delegates. Purpose of the letter was to explain certain information that the House of Delegates had asked the Blue Shield to obtain on its claim forms.

The Council then replaced certain vacancies that had developed in the Council-appointed committees and heard reports of the district grievance committees.

The Association's counsel, Mr. E. Gaines Davis, Jr., then reported on correspondence he had carried on with a staff member of the UMWA and received further instructions from the Council in the matter.

It was explained to the Council that the four-year term of office of Carl Fortune, M.D., Lexington, on the State Board of Health expired on December 31, and that the statutes provided that the Council of KSMA would recommend the three names from which the Governor would appoint one to fill the vacancy. The Council voted to submit the following three names to Governor Bert Combs: Carl Fortune, M.D., Lexington; William J. Temple, M.D., Covington, and Oscar Miller, M.D., Louisville.

George Archer, M.D., Prestonsburg, co-chairman of the KSMA Legislative Committee, was called on to present the recommendation of that committee. The Council voted to accept the recommendation that at least two men from each Congressional District plan to attend the KSMA dinner honoring Kentucky's Congressmen and Senators in Washington, February 25.

Proposed changes in the Indigent Care Bill, which was to be introduced in the 1960 General Assembly by the Council on Allied Medical Services, were explained by Mr. Grogan and approved. Mr. Grogan also explained the Legislative Committee's proposal for a Cancer Quackery Bill, and this recommendation was accepted.

The recommendation that the Quick Cremation

Bill, as explained be introduced in the Legislature was approved. Also, the recommendation that the Workman's Compensation limit be increased from $2,500 to $5,000 was approved. In addition, the Council then gave the go signal to proposed amendments that were designed to give certain authority to the local county health boards.

The Legislative Committee's recommendation that the request of the State Dental Association, which called for the addition of one member— a dentist— to the State Board of Health, and the addition of a dental member to each county board of health be rejected, was discussed at much length. The Council had also received a delegation of top officials from the dental association, who presented the matter for the dental association earlier that afternoon. When the question was put, the Legislative Committee's recommendation was rejected and the Council voted to support legislation which would allow an additional member, a dentist, on the State Board, and an additional dental member on each county board.

The Council also voted to authorize the Legislative Committee, in compliance with the action of the House of Delegates, to support the Constitutional Convention.

It was explained to the Council that the Legislative co-chairmen would, in the pursuance of their duty, make numerous phone calls. The recommendation that telephone credit cards be issued the Legislative co-chairmen, with the understanding that records of each call would be kept, was approved.

The recommendations of the Committee on Public Information and Service to the Council were presented. The first recommendation called for the approving of the organization of a chapter of the American Medical Assistants Association in Kentucky by the Council. After discussion, the Council authorized the chairman to appoint a committee of three to look further into this matter. The Council then approved the recommendation that the Director of Field Services offer a public relations course for physicians' assistants similar to the one that the Committee offered several years ago.

The next recommendation dealt with the request that the Association offer a model application form for county medical society use. The form was presented and accepted. It was also explained to the Council that a county medical society had asked for a suggested list of activities for use by county medical society officers. The list proposed by the Committee was approved.

The recommendation of the Committee on Public Information and Service suggesting a survey be made to learn the amount of free medical care and charitable work that was being done by physicians was rejected by the Council. Proposal for KSMA's support to the practical nurse training program was explained and approved. The recommendation that KSMA cooperate with Blue Shield in holding a meeting for all interns and residents going into practice July 1 was referred to the Board of Directors of Kentucky Physicians Mutual for final action. The recommendation that more information be disseminated on the medical rider coverage offered by Kentucky Physicians Mutual was referred to the Medical Advisory Committee on the Board of Directors of Kentucky Physicians Mutual.

The Council then listened to a letter from Thomas Ray, a representative in the General Assembly from Jefferson County, asking the Association to support the drive to resist moving the offices of the State Department of Health from Louisville to Frankfort. Careful consideration was given Mr. Ray's request. The Council voted to support Mr. Ray's suggestion that a special committee be appointed by the Governor to look into the situation. The statement approved by the Council then went on to say that the Council did not feel qualified to pass on this question and that after the Governor had considered all information that it would gladly accept whatever decision the Governor made in the matter.

A brief report on the relative value survey, which the Council previously authorized be made of the opinion of the various county medical societies, was given. It was felt that the number of replies could not justify a decision at this time.

The Council then recognized Carl Cooper, M.D., who has been the Association's representative on the steering committee that has been appointed to look into the matter of organizing a health council for the State of Kentucky. It was also pointed out that Hoyt Gardner, M.D., had been asked by the chairman of the Council to attend the last organizational meeting of the Kentucky Health Council. After hearing both men, the Council voted to support the Kentucky Health Council as long as it lived by the bylaws, as proposed, and authorized the chairman to appoint a committee composed of Doctor Cooper, Doctor Gardner and other physicians to represent the Association and also authorized the payment of dues levied by the Council.

It was then pointed out that the Council had gone into session at 10 a.m., and that it was 5 p.m., with many of the members having to travel long distances to their homes. While the agenda had not been completed, the Council adopted a motion to adjourn.

THIRD MEETING—The Council held its third meeting of the 1959-60 associational year at Owensboro, prior to the County Society Officers Conference. After hearing the President's report and the Headquarters Office report, the proposed budget for the 1960-61 associational year was presented. It was explained that the Budget Committee had spent a day going over and approving the budget as proposed, and that the Executive Committee had given careful attention to it, approved it and recommended to the Council that it be accepted.

After discussion, the Council voted unanimously to accept the budget and approved a recommendation of the Budget Committee, passed along through the Executive Committee that the Association appoint an investment committee, composed of the president of the Association, the chairman of the Council, and Keith Smith, M.D., Councilor from the Fifteenth District, to serve as an investment committee.

The Council then heard a discussion of how the new sales tax might apply to physicians, and it was stated unofficially that medicines given by the physicians in the treatment of their patients would not be subject to the sales tax. However, a sales tax would be collected on any medicines or appliances that were sold to the patient by the physician. It was indicated that as soon as the State Department of Revenue had drafted its regulation it would be circulated to the members of the profession.

Correspondence from the local UMWA administrator, Asa Barnes, M.D., Louisville, which related to problems the Welfare Fund was having with repeat hospitalization of patients, was read. Doctor Barnes had asked for suggestions from the chairman of the Council and the president, as to how this problem might be overcome. After discussion, it was agreed that the Association would be glad to cooperate in this problem, provided, however, that there could be full cooperation on all matters between the Association and the Fund, with respect to the Fund's program of medical care.

The Council heard correspondence read and listened to a discussion, relative to the appeal of a member of the Scott County Medical Society to the Council regarding an alleged grievance. The Council then voted to hold a meeting to consider this problem at a later date to be set by the appropriate officers of the Association.

Gaithel Simpson, M.D., chairman of the KSMA Committee on Medical Education and Economics,

explained the responsibilities of the Association in carrying out that portion of the Governor's Reorganization Bill, passed at the 1960 Legislature that deals with Article VII and the Medical Care Program for the Indigent. Following the explanation of the provisions of the Bill and discussion, the Council thanked Doctor Simpson for his efforts. It then made nominations for the appointments to fill offices called for from the medical profession under the act.

The KSMA representative on the steering committee set up to organize the Kentucky Health Council, Carl Cooper, M.D., Bedford, reported on the progress that had been made in organizing said council.

The Kentucky Surgical Society and the Southern Surgical Association were officially thanked for their $1,000 and $200 contributions, respectively, to the McDowell House.

The School Health Committee's request that a letter be sent to the Kentucky High School Athletic Association, stating the Association's willingness to help school teams in getting a physician, was approved.

The Committee on Public Information and Service was asked to restudy the matter of endorsing the operation of a statewide medical assistants group in Kentucky and to submit the matter to the 1960 House of Delegates. Mr. Joe Miller, AMA field service representative from Kentucky and former director of the Kentucky T. B. Commission, was introduced. Mr. Miller commented briefly on the growth of health insurance and legislative problems facing medicine.

FOURTH MEETING—On May 26, the Council held its fourth meeting of the year at the Campbell House in Lexington. The meeting was called primarily for the consideration of a problem within a nearby county medical society. After some five hours of consideration of the problem, the Council rendered its decision in executive session.

With very little time left, the Council authorized the delegates to the AMA to present a resolution commending the AMA on its vigorous and effective efforts to defeat the Forand Bill. It also heard the Warren County proposal, as presented by G. Y. Graves, M.D., Bowling Green, relative to recommendations on the medical care of the aged. After hearing the report, the Council voted to authorize its transmittal to the Board of Trustees of the AMA, for its consideration.

The Council accepted an invitation from WHAS Radio, Louisville, to cooperate in two fifteen-minute radio programs each week on that station. The invitation was accepted with appreciation and the KSMA Committee on Public Information and Service was authorized to work with the radio station.

FIFTH MEETING—The fifth meeting of the Council was held at the Brown Hotel in Louisville, Thursday, July 28.

Following the report of the president, the delegate to the AMA, and the giving of the Headquarters Office report, Sam A. Overstreet, M.D., Louisville, was elected editor of the Journal of KSMA for a second two-year term, and George W. Pedigo, M.D., Louisville, associate editor, was also elected for a second two-year term.

KSMA Bylaws Committee was authorized to study the recommendation that all KSMA offices be changed by the Bylaws not to exceed a three-year term.

Following the discussion of a recommendation that all KSMA Annual Meeting scientific programs and the scientific programs of councilor district meetings be qualified as acceptable for Category I credit under the American Academy of General Practice, the following motion was passed:

"At the invitation of the Kentucky State Medical Association, the scientific programs of the .... Annual Meeting and (as the case may be) councilor district meetings, be prepared with the active cooperation and assistance of the specialty groups listed below and presented by the Association under their co-sponsorship. It will be permissible for the following to appear in fine print and inconspicuously on the program: 'This program is acceptable for . . . . . hours of Category I AAGP credit.'"

The Council then accepted a recommendation from the KSMA Associate Committee on Insurance: (1) that the committee be authorized to serve as a clearing house to handle complaints by insurance companies against physicians and by physicians against insurance companies; (2) that the Council ask the Legislative Committee to study the desirability of proposing legislation to require certain standard provisions for health and accident policies; and (3) that a statement on bad practices be approved.

The appeal of the Society of Medicine, Pike County, for a charter was considered. Following the discussion, the appeal was not accepted— the decision being based on Chapter XII, Section 4 of the Bylaws.

Members of the Council were told that Resolution K, which related to a recommendation that an investigation be conducted to learn if there were any irregularities concerning the "code of conduct of physicians and osteopaths who might be engaged in the corporate or unlicensed practice of medicine, by reason of their connection with hospitals." The House of Delegates had voted to send this resolution to the state societies of radiology, pathology, and anesthesiology, with the request that this resolution be studied and recommendations be received. The June 30 Executive Committee of the Council reviewed the studies of the Association and referred them back to the KSMA Committee on Third Party Medicine.

This committee studied the recommendations of the three groups and made the following recommendation to the Council, which the Council accepted: "It appears from the responses of the three specialty groups, (anesthesiologists, pathologists, and radiologists,) that it is not expedient at this time for the Association to undertake to solve these problems by litigation. It is the recommendation of this committee that the possibility of sponsoring a professional practice act (as recommended by Past-president Mersch) be explored."

The Council heard the recommendation of the Legislative Committee which stated that while the key-man system had been working on the whole very well, there were certain weak spots which needed revamping. After discussion, the Council voted to authorize the Legislative Committee to make the proposed recommendations for the rebuilding of the system and report back to the Council.

There was then a discussion of Senate Bill 3570, Second Session, 86th Congress, which was described as the antivivisectionist bill and which was introduced by Senator John Sherman Cooper and others. Following the discussion, the Council went on record as opposing the Bill in toto.

The Commissioner of Health, Russell Teague, M.D., Frankfort, told of the progress that was being made in setting up the new indigent medical care program passed by the Legislature at its 1960 session. He noted the important part that physicians played in making the program a success.

At the March 30 meeting of the Council in Owensboro, the report of the Committee on Medical Education and Economics concerning the relative value study was discussed. Since the Council did not act at that time, on the recommendation, it was again discussed at the July 28 meeting. When it was learned that there was relatively little interest in this subject, a motion to table the matter at this time was passed.

The Council was told that the date of the Officers

Conference had been set for April 6, 1961, and that it would be held at the Phoenix Hotel in Lexington.

The Council also decided to hold the fourth annual dinner honoring Kentucky's senators and congressmen in Washington, on Thursday, February 23.

The Council voted to ask the president and the chairman of the Council to appoint a membership committee which would have two objectives: (1) making sure that all physicians who should be members would have an opportunity to join KSMA, and (2) increasing the membership in the American Medical Association.

The Council voted to authorize its chairman to appoint a committee to study the Jefferson County Armory as a possible meeting place for the KSMA Annual Meeting. It was leaned that the Jefferson County government planned to spend $670,000 in renovating the building.

Carlisle Morse, M.D., Louisville
Chairman
Council of KSMA

Recommendations, Reference Committee No. 1

The Committe has carefully considered the report of the Chairman of the Council and recommends its adoption. The Committee feels that certain items of the report should be further elaborated.

At its meeting on July 28, the Council voted that the KSMA Annual Meeting scientific program and the scientific programs of the councilor district meetings be prepared in such a way that they be qualified as acceptable for Category I Credit of the American Academy of General Practice. Your Committee feels that this is a desirable move and believes that it should make such meetings of greater value to the profession in the State.

At the same meeting, the Council accepted a recommendation from the KSMA Associate Committee on Insurance which follows:

> "(1) that the committee be authorized to serve as a clearing house to handle complaints by insurance companies against physicians and by physicians against insurance companies; (2) that the Council ask the Legislative Committee to study the desirability of proposing legislation to require certain standard provisions for health and accident policies; and (3) that a statement on bad practices be approved."

Your Committee feels that this is a very wise action. Particularly in view of the fact that commercial insurance companies are being considered as allies of the medical profession in combating governmental intrusion into the field of medical care, it becomes the concern of organized medicine to be on guard against that minority of insurance companies which write unacceptable insurance contracts.

At its June 30 meeting, the Executive Committee considered the mandate of the 1959 House of Delegates to investigate the problem of third party medicine and referred this to the Committee on Third Party Medicine.

At the July 28 meeting of the Council, the report of the Committee was considered and the Committee recommended that no legal action should be taken at this time but that the possibility of sponsoring a Professional Practice Act (as recommended by Past-president Mersch) be explored. Your Committee agrees with this recommendation.

The Council also asked the President and Chairman of the Council to appoint a membership committee with two functions:

(1) to make sure that all physicians who should be members would have an opportunity to join KSMA, and

(2) to work toward increasing the number of AMA memberships.

It has been pointed out that Kentucky will get a third delegate to the AMA if about 170 more KSMA members pay AMA dues. It is urged that this recommendation be carried out.

A supplemental meeting of the Council was held on September 19. At this meeting an amendment was approved to the existing employees' pension plan which raised the maximum benefits to more realistic benefits. Your Committee believes that this is a commendable and wise action.

At this same meeting, the Council voted to recommend to the House of Delegates that approval be given to a Better Roads Council. Your Committee agrees with this recommendation.

Your Committee feels that the Council of KSMA deserves the thanks of all the members of the Association for the time and effort it has expended; for the wise and careful management which they have given the affairs of the KSMA.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Report of the Secretary

In our report to you one year ago, we predicted: "We can look forward to much progress during the coming year as a result of the expanded program that this House of Delegates voted in 1958." We are glad to report our prediction has been realized. Nothing of a sensational nature has been experienced, but much good solid progress has taken place in areas where it was most needed.

For example, the Committee on Postgraduate Medical Education has launched its program. A full-time director whose name is Friedrich Hertle, Ph.D., has been on the job nearly a year. The medical schools of both universities are cooperating, along with the U.S. Public Health Service, the Kentucky Academy of General Practice, and other specialty groups. An office has been provided by the University of Louisville, along with a part-time secretary. In addition to its function in the area of coordination, it has presented one course, and has several courses in the planning stage.

In the field of medical care for the aging, there has been much activity and considerable progress made. KSMA representatives have attended several national meetings, and three of our members participated in the AMA-sponsored Conference on Aging in Cleveland. Many of our members, together with a member of the staff, have been active in preparing for the Governor's Conference on Aging, a prelude to the White House Conference on Aging, which was held September 1 and 2 (after this report was written). Five KSMA members have been appointed by the Governor as a part of the 32-member delegation from Kentucky to the White House Conference on Aging in Washington, early in 1961. Our committee on aging has been quite active in covering its responsibilities.

On the legislative scene, the KSMA has been very active at both the state and national levels during the past year. The newly developed Legislative Key Man System, with manual giving the blueprint for its operation, has been in operation for some ten or eleven months and not only has its effectiveness been demonstrated, but it has attracted national interest. The AMA has sent a copy of the manual to each of the 50 states and a number of letters have been received in this connection in the Headquarters Office.

At Frankfort, all major health legislation held to be in the public interest and supported by the Association passed. The value and importance of the Legislative Key Man System was emphasized. Also, some soft spots were detected and the Council has authorized the Legislative Committee to bring in recommendations designed to correct these. We should not overlook the fact that, of the 285 Senate

bills and 547 House bills introduced in the 1960 Legislature, 103 had medical implication with interest to the health of the people of Kentucky. Nineteen Senate bills and 27 House bills with medical implication became law and KSMA did not actively oppose any of this number. It is no small undertaking, screening these bills and following them through the tedious legislative procedure. However, this is as important as it is time consuming, and our Legislative Committee, our legislative representative, and legal counsel deserve our deepest appreciation.

The importance of this Association's working with other groups, who share our views in passing legislation in the public interest, was effectively highlighted during the 1960 Legislature. Last year we reported that "we must recognize that some form of indigent medical care will be voted by the 1960 Legislature." The Legislature this year did vote this program and, cooperating with our sister professions of dentistry, hospitals, nurses and pharmacists, we believe the best possible legislation from both the standpoint of the patient, the taxpayer, and those who render the service, was passed.

If we may be allowed editorial license at this point, we would strongly urge that you go back to your local county medical societies and urge full cooperation with the appropriate authorities in an effort to make this bill work. We of the medical profession are now senior partners in this program; our responsibility is clear, and you can be sure that our performance will be carefully watched. Our failure to live up to our obligations will only reflect on the good name of the profession. We urge you to inform yourselves; make sure your county society advisory indigent care committee functions. If we fail in this program, then we may as well admit that socialization of medicine is the only way.

Of the more than 19,000 bills introduced in the 86th Congress, 739 had medical interest. Of these, medicine has supported 25, opposed 6, and given information on 8. Forand-type legislation has dominated the entire second session and adjourned session of this Congress. The growth of our effectiveness on the national scene can only be measured by the willingness of each individual to discharge his obligation. We can report encouraging progress. Through our annual KSMA dinner honoring our senators and congressmen, our efforts to inform them of what we feel is best in the public interest, both when they are at home and in Washington, is bearing fruit.

Kentucky is blessed by having some excellent representation in Congress. Each of the eight congressmen and one senator are coming up for re-election. Once more, you are urged to support the men who are best equipped to represent you. Certainly we go along with the popular TV campaign that we should support these men with our time, money and influence.

We have purposely allowed our discussion of legislative problems and progress to dominate this report. We have done this because of its obvious importance to our patients and to us at both the state and national levels, now and in the future. This does not mean that progress has not been made elsewhere.

The work of the Rural Kentucky Medical Scholarship Fund and Placement Service is progressing in a very satisfactory manner. Our Association is rendering an increasingly useful service in this area.

The recommendations of the KSMA Advisory Commission to Blue Shield have been accepted and extensive studies are now being carried on to equalize allowances under the basic certificate.

Time does not permit the mentioning of all fronts on which progress has been experienced—your envelope containing the reports will give this information. We would like to point out that the New Member Luncheon was very successful last year, and the second will be held tomorrow.

Our Journal of KSMA will be host to the editors and staff of other state medical journals in Lexington next month. Much time and effort have gone into developing this Third Regional Medical Editors Conference, to which all states have been invited.

Francis Massie, M.D., Lexington, recipient of the 1959 KSMA Distinguished Service Medal, has asked me to express his appreciation to you for this honor he treasures so highly.

Speaking of expanded activities, it should be pointed out that, as we approve additional programs of the Association in this body, we have to look to our Headquarters staff to implement them. Since the activity of the Association has increased approximately 50% since it was decided to occupy our present quarters nearly four years ago, we must in some way make provision for additional space. Our operation, because of cramped quarters, cannot render the kind of service it is capable of doing.

Once again, I want to express my appreciation to the officers of the Association, the members of the Council, the KSMA Committees, and to you of the House of Delegates for all the good work you have done. Also, I want to thank the Headquarters staff members for their cooperation with my office.

Woodford B. Troutman, M.D.
Secretary, KSMA

Recommendations, Reference Committee No. 1

The Committee carefully considered the report of the Secretary and was much impressed by the magnitude of the activities of the office. It is the feeling of the Committee that sincere appreciation should be expressed for the time, effort, wisdom and judgment which has been displayed by our Secretary, Woodford B. Troutman, M.D.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the Editor of the Journal

During 1959 and 1960, George W. Pedigo, M.D., Associate Editor, Mr. Joe Sanford, Managing Editor, and I have tried diligently to keep the affairs of our Journal on as high plane as possible and to improve its effectiveness to the profession.

The Insurance Page instituted a year ago has been carried out regularly and apparently with considerable benefit to our program of voluntary insurance. Vinson Pierce, M.D.'s work on this feature has been highly effective.

Policies regarding the editorial page have not been changed except for the acceptance of somewhat longer scientific editorials than we had used in the past. These editorials have been well received and, we believe, add significantly to the value of the Journal.

One meeting of the Editorial Advisory Board has been held. No important changes in the Journal were recommended.

Your editors and managing editor in November, 1959, attended the meeting of State Medical Journal Editors held in Chicago under the sponsorship of The State Medical Journal Advertising Bureau. Instruction and exchange of ideas at that meeting have been used with profit in the improvement of our own Journal.

The KSMA Journal is sponsoring a Regional Meeting of Editors in Lexington, Kentucky, October 15th and 16th, 1960. Our advance information indicates that this conference will be attended by representatives of the Medical Journals throughout the Southeastern area and beyond. Mr. Sanford has spared no time nor effort to make this a successful and profitable meeting.

At the July 28th Meeting of the Council, Dr. Pedigo and I were appointed for an additional two-

year period. It will be our purpose with the help of the Editorial Advisory Board and approval of the Council to continue our efforts to improve the Journal.

Sam A. Overstreet, M.D., Louisville
Editor of the Journal
Kentucky State Medical Association

The Report of the Editor was carefully considered. The excellence of the Journal is well known to all members of the Association. The Committee wishes to express appreciation not only to the editors but to the many other individuals, including the contributors, who have helped in making our Journal what it now is.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the Treasurer

Mr. Speaker, the report of the Treasurer includes an audit by certified public accountants outlining the financial affairs of the Association. The Committee considered this report and will not attempt to cover it in detail, but wishes to point out that the auditors found the records of the Society in excellent condition. The Committee recommends that the treasurer and his office force be complimented for their excellent services.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Report of the Delegates to the American Medical Association

The detailed reports of your delegates to the AMA concerning the clinical session in Dallas, December 1-4, 1959, and the annual meeting in Miami Beach, June 13-17,1960, have already been published in the Journal of the Kentucky State Medical Association. Robert Long, M.D., reported on the Dallas meeting in the February, 1960, issue of the Journal, and Vinson Pierce, M.D., reported on the Miami Beach meeting in the August issue.

Since reports of the Dallas and Miami meetings were fully covered in the JOURNAL OF KSMA and were available both to the entire membership as well as the delegates it was not felt necessary to go to the expense of duplicating this material and mailing it out to the members of the House.

Some of the recommendations and policy statements of the AMA House of Delegates, and of the officers of the AMA seem important enough to merit re-emphasis in this report.

One of the most important statements made at the Dallas meeting was the one which was introduced by Doctor Long as a substitute amendment regarding freedom of choice, in which it was stated that "The American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of or abridges such freedom of choice and such competition." This amendment was adopted by the House of Delegates by a 2 1/2 to 1 majority.

The chief problem confronting organized medicine in the past year has been the care of the aged. The platforms of both major parties for the presidential election this year call for the Federal Government to take an increasing role in providing health care for the older citizens.

The viewpoint of the American Medical Association is now, as it has been in the past, that the health care of the individual is his own primary responsibility. If he is unable to provide such care, then the responsibility should pass to his family, the community, and the state, in that order. When, and only when all of these fail, should the Federal Government assume this responsibility and then only in conjunction with the other levels of government in the above order.

The House of Delegates went on record as favoring more jobs for the aged, voluntary rather than compulsory retirement for those still able to perform their duties efficiently; and urged that a strong campaign be waged against job discrimination because of age.

The various state societies were asked to take an active part in state conferences and other planning activities preceding the January 1961 White House Conference on Aging.

At both the Dallas and the Miami Beach meetings the House of Delegates strongly expressed its opposition to compulsory inclusion of the physicians under Title II of the Social Security Act; thereby reaffirming the previous position of the House.

Both Doctor Orr, the outgoing president of the AMA, and Doctor Askey, the incoming president, stressed the need for recruiting of capable young men and women to take up medicine as a career. A special committee of the AMA Council on Medical Education and Hospitals has been working during the past year to develop meaningful recommendations which will result in increased aid to deserving medical students in the form of scholarship and loan funds. Component medical societies, as well as individual members, are urged to aid in the recruitment of qualified young people.

During the past year, the AMA has again expressed its deep interest in the principle of voluntary prepayment for health care; and in particular has reiterated its support of the Blue Shield Plans, which act as an economic arm of medicine in providing the necessary health care for our people. Physician participation in the Blue Shield Plans is strongly urged.

Individual members of the AMA were urged by President Orr to take a greater interest and a more active part in public affairs at all levels.

One of the specific recommendations in Doctor Orr's final report to the House of Delegates was that county and metropolitan state associations adopt a rural village, a city or a region in another continent with the sole purpose of helping to improve the health care of the area. This recommendation has been referred to the Board of Trustees for study; but the House of Delegates has strongly approved the idea, and urged that it be given serious consideration.

Your delegates and your alternate delegates again wish to thank this House of Delegates for the confidence you have bestowed on us, and to assure the members of the Kentucky State Medical Association that we have tried to the best of our ability to merit this confidence.

Each of your delegates and alternate delegates has been present at all of the sessions of the House of Delegates of the AMA at both meetings during the past year. Others who attended the sessions of the House, and the various reference committee meetings and who also helped our delegation in other ways included the President and Executive Secretary of the KSMA, the Field Secretary of the KSMA, and many members of our state association who gave generously of their time and energy. To each of these, we are most grateful.

We especially wish to thank Mr. Sanford and his staff for their untiring help throughout the past year.

KSMA Delegates to the AMA
W. Vinson Pierce, M.D., Covington
Robert C. Long, M.D., Louisville

Recommendations, Reference Committee No. 1

The Committee carefully considered the report of the Delegates to the AMA. We wish to call attention to the amendment offered by Robert C. Long, M.D. at the Dallas Meeting, which stated as follows:

"The American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of or abridges such freedom of choice and such competition."

The KSMA has repeatedly explained itself in favor of free choice of physician but your Committee recommends that the House of Delegates reiterate its position in endorsing Dr. Long's amendment.

Your Committee recommends that the KSMA endorse the viewpoint of the AMA on medical care of the aged, as reported in the report, and quoted below:

"The health care of the individual is his own primary responsibility. If he is unable to provide such care, then the responsibility should pass to his family, the community, and the state, in that order. When, and only when all of these fail, should the federal government assume this responsibility and then only in conjunction with the other levels of government in the above order."

Your Committee further recommends that the KSMA endorse the viewpoint of the AMA as quoted below:

"The House of Delegates went on record as favoring more jobs for the aged, voluntary rather than compulsory retirement for those still able to perform their duties efficiently; and urged that a strong campaign be waged against job discrimination because of age."

The Committee feels that special mention should be made of the substantial services of the senior delegate, Vinson Pierce, M.D., who has been invaluable in his efforts and the national recognition he has received. We recommend that the House of Delegates express appreciation to its delegates to the AMA for their faithful service and excellent work.

Mr. Chairman, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the Executive Secretary

Our report to you in 1959 related primarily to the assignments of members of the KSMA Headquarters Staff under the expanded program you voted at the 1958 meeting. In this report, we will deal for the most part with activities of our staff so that you will know how our time is spent.

In addition to routine duties and special assignments, at least one staff member attended the 56 KSMA committee meetings during the year. This involved preparing and distributing the notices, preparing the agenda under the supervision of the chairman, writing and distributing a digest of the meeting, followed by the implementation of the directives of the committee.

Members of the staff attended 18 county and district medical meetings in Kentucky and 12 outside of Kentucky. Expenses for five of these out-of-state meetings the executive secretary attended were paid for by other organizations.

The staff, in addition, was represented at 48 meetings of allied and related groups and governmental agencies in Louisville and nearby locations in which medicine has an interest. These meetings serve a two-way purpose in that they offer the opportunity to render a service and to keep abreast of what is going on in related fields.

Our Director of Field Services spent 60 days in Frankfort with the State Legislature between January 7 and March 19, working under the supervision of the Legislative Committee, looking out after legislative proposals of the committee and screening 285 bills introduced in the Senate and 547 introduced into the House. He found that 103 bills had medical and health implications.

Our Executive Assistant was "loaned" to the American Medical Association for 31 working days between January 8 and April 16. He worked in Kentucky and West Virginia on medical legislation being considered by the Congress. For his service to it, the AMA paid his salary and expenses.

Not included in the above are 46 meetings at 7:30 on Monday mornings in the Headquarters Office, attended by the editor, Sam A. Overstreet, M.D., and associate editor, George W. Pedigo, M.D., the executive secretary (managing editor) and the assistant managing editor of the Journal. Members of the staff deeply appreciate the supervision, devotion to duty, and cooperation of the editors.

Attendance at the KSMA Annual Meeting or any of its collateral meetings during the annual session are not included in this report.

We wish it were practical to report to you the number of hours that it is necessary to spend on the telephone in the conduct of the Association's business, especially during years that the Legislature meets.

Preparation for and promotion of major association activities absorb much staff time. For instance, just one item in the preparation for the Annual Meeting involves much of the secretarial staff's time. That item is your House of Delegates envelope. For instance, in the 1959 folder, which was one of average size, a total of 32,850 pages had to be processed and assembled.

Other major activities, in addition to the Annual Meeting, are The County Society Officers Conference, Senior Day, The Rural Health Conference, The Athletic Injury Prevention Conference, Diabetes Detection Drive, and the state-wide immunization program.

The Headquarters Office wrote, processed and distributed the material for the promotion of 13 councilor district meetings (several of these were joint sessions).

Staff members working on the Journal assembled, coordinated, and met the necessary deadline for a total of 1,608 pages of the 12 issues of the Journal of KSMA. A substantial portion of the non-scientific material in the Journal is written by our assistant managing editor.

In addition, under direction of appropriate officials, the staff prepared and distributed the two news letters the Association mails to its members each month. Twenty statewide and regional news releases were prepared and distributed. Layout and copy were prepared for six promotional pieces used in Association work.

It is conservatively estimated that a total of 61,000 individual pieces of mail were processed and distributed during the year.

The staff cooperated with members of the Association in obtaining material and writing of their speeches. Numerous requests for material by students and lay people were filled. Staff members spoke to civic clubs.

The foregoing is a description of those activities that lend themselves to easy and fast reporting. Not included in these comments are the less dramatic and most important solid routine duties, including the bookkeeping and the membership records which our staff members do so well and which are so necessary.

The members of our staff join me in expressing appreciation to the officers and members of the House of Delegates and the Council for the opportunity of working with you. We want to especially remember our secretary, Woodford B. Troutman, M.D., who has given unselfishly and generously of time and advice.

To each member of the Headquarters staff, I want

to express my gratitude and thanks for your dedication to duty, loyalty to the Association and efficient performance of your duties.

J. P. Sanford
Executive Secretary

Recommendations, Reference Committee No. 1

The Committee considered the excellent report of the Executive Secretary. Even though this indicated a tremendous amount of work, your Committee knows that it expresses only in the most outlined form the invaluable services of our executive secretary and his staff. The Committee recommends acceptance of this report and the thanks of the House of Delegates to them for the excellent work of the entire KSMA Headquarters Staff.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Report of the Committee to Study New Home for KSMA

One year ago, by resolution, you directed that a Committee "study the feasibility of the Kentucky State Medical Association

1. Purchasing a new lot and building its own building
2. Purchasing a suitable building for occupancy
3. Making recommendations on how the project in either case might be financed."

The Council appointed as the committee N. Lewis Bosworth, Hoyt D. Gardner, and George F. Brockman, chairman. Having traveled 6,000 miles, held nine days of conferences, and digested several pounds of documents, we now submit the report as directed. It summarizes as briefly as possible

1. An analysis of the problems
2. Our findings in approaching a solution, and
3. A specific method of financing

The Association

The Kentucky State Medical Association is a voluntary association for the advancement of science, exempt from income taxes for federal and state purposes. The membership includes the overwhelming majority of Kentucky physicians. Probably it will always represent approximately the same high percentage of Kentucky physicians. The literature on projections in physician populations is extensive, but conflicting. For this study, your Committee assumes that the membership will probably show a steady growth at a rate greater than that of the general population, influenced possibly by the presence of a second medical school.

For consideration in a headquarters building, the activities of the Association can be grouped into two general categories:

a. Policy making, generally those activities performed by the members, including the assemblage of this House, the Council, the various committees of members, and many of the activities discharged by elected officers, including the President, the Treasurer, the Editor of the Journal and his advisory group, and

b. Executive and administrative functions, including the publication of the Journal; bookkeeping and account collection, both for the members, the Journal, and the annual convention; similar activities to implement the policies established by the members.

The Present Headquarters

The headquarters currently occupies 1200 sq. ft. on two floors in a commercial building. Rent of $4,000.00 annually is at a bargain rate, having been exceptionally well negotiated. There are no facilities for the activities of the members of the Association. The President can confer with a visitor only by displacing the Executive Secretary from his office. The committees of the members, including the Trustees, meet where best they may, usually in hotels or commercial food-handling establishments.

Because of the Association's expanded programs, activities of the administrative staff have increased approximately 50% since these quarters were obtained. All office workers are inefficiently crowded elbow to elbow. Floor space is actually inadequate to accommodate the business machines used for duplicating, mailing, and other mechanical processing. Storage space is inadequate for the volume of materials required for economical operation.

Experience of Other Associations

The associations of seven other southern states, all with recent experience in headquarters construction, were most kind in providing blueprints, pictures, specifications and observations about financing. Three associations (Mississippi, Alabama and Tennessee) were found to be nearly comparable to the Kentucky Association in size, relative financial strength, and similar characteristics. By careful scheduling, the Committee, together with an architectural consultant, was able to inspect these three homes.

There was found to be much similarity in basic structure. The meeting of the Council was the largest group for which facilities were designed. Additional provisions were made for meeting rooms for smaller committees. Otherwise, the basic structures were designed for the efficient performance of the business of the Association. Much thought is devoted, for instance, to the design of the make-up room for the Journal, and similar details of operational efficiency. All buildings had been constructed from current resources, all were adequately financed, and all members of the respective associations were uniform in condemning the thought of assessments or dues increases.

Consideration of the Headquarters function of the Kentucky Association indicated that a total of 5000 sq. ft. of "working area" (exclusive of heating and corridors) would provide for efficient function under present circumstances. It was felt that adequate provision should be made for expansion, vertically, horizontally, or both, if Association activities should be expanded by future developments. It is noted that the British Medical Association, for example, underwent marked expansion with the advent of state medical care.

Financial Appraisal

Under the guidance of a financier of ability and distinction, pertinent financial considerations were explored. It was found desirable that a voluntary association maintain a liquid reserve approximately equal to one year's operating expense. This was felt particularly desirable in the case of this Association, whose membership might be subject to extreme fluctuation in time of war or a national emergency. It was found that, in new construction on a desirable site, the Association would qualify as a satisfactory borrower at a minimal rate of 6% interest, on loans ranging to 50% of the investment represented.

Used property is regarded much less favorably by responsible lenders, being subject to many variables as regard the adjacent neighborhoods, state or preservation, the degree of rehabilitation or remodeling deemed advisable, and a host of other problems. The Committee found that for a satisfactory investigation of previously constructed property, at least $1,000.00 should be available for appraisals and for engineering and architectural estimates. It is further felt that a committee for purchase of used property should be given final authority for closure, either on its own

motion or on approval of the Councilors. This market is subject to rapid fluctuations.

A review of the current financial status of the Association indicated that the current reserves would allow the diversion of $75,000.00 from the liquid form to a more fixed type of asset. In addition, the trend of receipts indicates that the Association would still be of a quite favorable conservative cast if the annual rentals were doubled to $8,000.00.

Economic analysis demonstrates that a tax-free association dissipates resources by any long-range use of commercial renting. If the group be considered as renting to itself, however, an entirely different pattern is presented. Assume this Association to invest $75,000.00 in a first-class construction on a desirable site. A loan of $75,000.00 would be available to permit an investment of $150,000.00. Assume that it pays $8,000.00 annually for rent. If a conservative $1500.00 per annum is estimated for expenses of ownership not now pertaining (real property taxes, insurance, etc.) it is found that the Association would recover the cost of its investment in retiring the loan in twenty years. At the end of twenty years, there would be due a final payment of $328.00 on the 241st month.

Having established a very conservative delimitation on construction on a sound "commercial" basis, the committee considered other methods of fund raising. Three of these, which have appealed to the Committee, are described in an appendix to this report. It is felt that they may well have merit for other purposes, or as supplemental financing for building purposes.

Site Location

The Committee has made extensive site-location surveys. On the basis of confidential information submitted on identical questionnaires by the respective Chambers of Commerce of Frankfort, Lexington, and Louisville, there appeared little choice but to recommend that the Headquarters remain in Louisville. Considering that the majority of members live outside Louisville, it was felt that a site on major arterial communications was essential. In considering the personnel problems of the administrative staff, it was recognized that central mass transportation was essential. Within these limitations, the Committee performed exensive leg work. Numerous conferences were held with realtors, architectural advisors, the University of Louisville, and the Kentucky State Fair Board. From these surveys, the Committee has received a firm offer of a site comparable to that of the Blue Cross-Blue Shield Building in accessibility, distinction, and neighborhood-protection.

The Building

Only with the internal space requirements developed, and a site available, were preliminary architectural studies for cost estimates possible. Through all of history, preliminary estimates have been notoriously too low. This Committee has made every effort to submit the following as maximum figures. Specifically, $5,000.00 could be reduced from the cost of the designated site by the purchase of one less lot. We have tried to include similar leeway in the other items. A distinctive functional building, of adequate size, in a prestige site, yields estimates of: Site $35,000.00; Building $100,000.00; Contingencies $4,000.00; Furnishings $10,000.00..Total $149,000.00.

Summary

With an investment of $75,000.00, by doubling the modest annual rental, the Association can somewhat more than quadruple the headquarters space, and recover the investment in twenty years.

Recommendations

Your Committee finds that a distinctive building, adequate for present functions and providing suitably for future expansion, can be constructed on a site of distinction and accessibility, in a protected neighborhood, for $150,000.00. This is within the current financial resources of the Association, and your Committee recommends that this construction be authorized.

N. Lewis Bosworth, Lexington, Kentucky
Hoyt D. Gardner, Louisville, Kentucky
George F. Brockman, Greenville, Kentucky, Chairman

Conclusion

The customary words of courteous closure are totally inadequate to describe the work of N. Lewis Bosworth and Hoyt D. Gardner on this Committee. Neither has missed a committee meeting. Both have devoted uncounted hours to the investigations and researches which have made this study possible. Their devotion and diligence have been magnificent.

George F. Brockman
Greenville, Kentucky

Supplementary Observations on Financing A Headquarters Building

All other State Societies were found to have financed construction from reserves and operating funds, with mortgages and bank notes used as needed. Having established the feasibility of such construction by this Association, the Committee feels that this should be the basic plan of financing. Three supplemental forms of financing were thought to have merit, and are submitted for possible consideration.

The Alabama State Society wrote a low-pressure letter to all members. This announced that construction was being started, and barely admitted that contributions would be accepted. There was no follow-up in any form. $11,000.00 was received from members with an impulse to spontaneous generosity.

Hugh L. Houston, M.D., of Murray, suggested the possibility of the establishment of Life Memberships in this Association. A limited number of members would be excused from all further payment of Association dues, after having made a contribution of $1,000.00 toward a Building Fund. In a brief discussion of this plan, the Committee learned of at least five potential "Life Members."

It is possible that funds for worthy purposes of the Association, or of organized medicine, might accrue if some formal mechanism for handling gifts was established, and quietly publicized. The friends, family, or associates of a deceased physician might desire to memorialize him in some manner through contribution to the activities of the Association. Component medical societies might desire to memorialize a deceased member. A possible mechanism would be the establishment of an "Endowment Committee." This could be composed of senior statesmen of the Association (possible past presidents) who might be authorized to accept gifts in the name of the Association, arrange for their use in accordance with a donor's instructions, and suitably express the gratitude of the Association. In the instance of the currently-proposed Association Headquarters Building, it would seem possible that someone might care to provide the furnishings for the Office of the President, in honor of some deceased President.

Recommendations, Reference Committee No. 1

The Report of the Committee to Study the New Home for KSMA was considered very carefully. The Association is deeply indebted to Drs. Brockman, Bosworth and Gardner for the tremendous amount of time and effort which obviously went into their very thorough report. No objections to the report were received by your Reference Committee and the Com-

mittee is convinced not only that our present quarters are inadequate, but that suitable headquarters should be constructed as soon as possible.

Your Committee therefore recommends that Report 21 be accepted with approval; that the appropriate officers of the Association be authorized and directed to purchase the site recommended by Dr. Brockman's Committee at the stated price of $35,000; that the Board of Trustees be authorized and directed to proceed at once with the construction of a suitable headquarters building on that site, to be financed in such manner as the Board may deem most advantageous, and that Dr. Brockman's Committee continue to function in an advisory capacity to the Board.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried, after a brief discussion.

Mr. Speaker, I move the adoption of this report as a whole. The motion was seconded and carried.

Reference Committee No. 1

Carl Fortune, M.D., Lexington, Chairman
Bruce Hamilton, M.D., Shepherdsville
W. R. Houston, M.D., Erlanger
L. P. Moore, M.D., Owensboro
Guy Cunningham, M.D., Ashland

REFERENCE COMMITTEE NO. 2

B. J. Baute, M.D., Chairman

Reports on Medical Care, Medical Education Hospitals and Related Subjects

During the fiscal year, 1959-1960, of the Kentucky State Medical Association, its Committee on Medical Education and Economics discussed the following listed topics and took action on each as recorded.

1. Shortly after the 1959 annual meeting the Council received a letter from Dr. Russell Hall of Wheelright, Kentucky, containing a suggestion that any physician wishing to practice a specialized field, in Kentucky, be required to have two years of General Practice prior to specialization. This thought-provoking and possibly controversial matter was referred to the Medical Education and Economics Committee for action. It was discussed freely early in the year, and at the last meeting of the Committee final action was taken. After thorough exploration of the subject by all members of our Committee, it was the feeling that the proposal had merit and perhaps would be beneficial for the physician, and could possibly contribute to solving the problem of poor distribution of general practitioners in rural Kentucky. However, from a practical point of view, a question arose as to the feasibility of controlling this situation by compulsion. It was, therefore, recommended to the KSMA Council that no action be taken.

2. In the matter of the relative fee value study, although opinion did not seem to be unanimous on the Committee, it was deplored that the various county medical societies showed so little interest in this matter. It is still the feeling of the majority of the members of the Committee on Medical Education and Economics that organized medicine should take the initiative in providing to both the public and, particularly, insurance carriers the relative value of fees of various services rendered. No other group of individuals who dispense commodities totally necessary to the welfare of our citizens have such arbitrary latitude in arriving at the value of such services, usually after rendered, as does our profession. This is a "sore spot" in our public relations.

3. The Council of KSMA requested this Committee to prepare the necessary mechanics for the members of our profession to take advantage of the provisions of the Jenkins-Keogh Bill, if, and when, it becomes law. Early in this year we made contact with three financial institutions in Louisville, securing from each an outline which they would recommend for the fruition of this program. The institutions contacted were: The Louisville Trust Company, The Lincoln Bank and Trust Company, and The Citizens Fidelity Bank and Trust Company. The details of the plans suggested by these institutions are on file in the State Office of KSMA. For the sake of brevity of this report, no details will be included. At the date of filing this report, the Jenkins-Keogh Bill has been passed by the House and also by the Senate Finance Committee, but has not been presented to the Senate for its consideration. In the event it becomes law, this Committee will make definite recommendations concerning a plan for participation of members of KSMA.

4. The American Medical Association requested an opinion from the Kentucky State Medical Association concerning the advisability of AMA sponsoring a group annuity or group disability insurance plan, or both. This matter was also referred to our Committee for an opinion. After consideration, it was the feeling of the Committee on Medical Economics and Education of KSMA that the AMA should not concern itself with these two plans, but should confine its activities to other areas in serving their membership. It is noted that many other professional groups with which many of KSMA members are already affiliated have such plans. In each instance the questionnaire was answered with a footnote added explaining that these ideas were those of our Committee and did not necessarily reflect the opinion of the majority of the KSMA membership.

5. Doctor Dickinson, a member of the Committee, and Chairman of the Sub-Committee on Insurance, discussed the advisability of KSMA making some attempt to expose, as such, the medical insurance groups who write inferior medical policies for the public. We suggested that the Committee on Insurance should look into this matter and report directly to the Council any recommendation which it might have, after investigation of the problem, possibly with the assistance of the Commissioner of Insurance of the State of Kentucky. This report was made to KSMA Council on July 28 by Doctor Dickinson.

6. The Chairman of the Committee on Education and Economics requested that the various members of the Committee give thought to the possibility of recommending to KSMA that it sponsor a program pointing toward the establishment of Nursing Homes which might be loosely contiguous with many of the general hospitals in the state, thereby establishing nursing home facilities, of standard quality, which would be under professional observation and yet could be staffed by practical nurses with graduate supervision. This arrangement could provide services at a figure competitive with the existing nursing homes, and the quality of care could be standardized.

7. This Committee is finally able to report to the House of Delegates that the efforts which it has been making for a number of years to establish, on a limited basis, a medical care program for the indigents in this state, were rewarded by the law being established in the 1960 General Assembly and will become operative January 1, 1961. Thanks to the Legislative Committee, KSMA, under the very able leadership of its Chairman, Doctor Norvell, and to the effective efforts of our Frankfort KSMA representative, Mr. Bob Grogan, the Council of KSMA, persuant to Section 12 of the Indigent Medical Care Act, has submitted names of three physicians to Governor Combs, from which list a physician will be selected to serve on its Indigent Medical Advisory Committee to the Governor. It has also appointed the State Advisory Committee which will represent

KSMA in presenting matters concerning the physician participation in its program, etc., to the Governor's Advisory Committee; and is in the process of selecting the county usage or screening committees in each county of Kentucky.

It has been my pleasure to serve as Chairman of this Committee since 1952 when our survey was made and the efforts to secure passage, through our General Assembly, of Legislation to establish an Indigent Care Program was begun. I am quite willing to admit that the subject of indigent care as proposed by this program is a controversial subject and that there are many honest differences of opinion in our profession concerning it. I have had more than one physician say to me that it appeared to be a socialistic approach. Let me assure you, gentlemen, that your conservative Council and House of Delegates during these years have been far-sighted in encouraging the establishment of this Program. It is clearly the feeling of the American Medical Association and a large majority of the State Medical Association that providing a workable, intelligent and democratic plan for supplying necessary medical care, in its broad sense, to the bona fide indigent is logical. It will go far to silence the clamor of the demagogue to furnish care to many who do not deserve, need, or wish it. I cannot fail to remind you that it will take eternal vigilance on the part of the usage committees on a local level, and the State Advisory Committee on a state level, to keep the plan within its proper perspective as relates to scope, size, cost, efficiency, etc. We must not fail the taxpayer in this obligation.

The data of Doctor Dickinson, Chairman of the Insurance Committee, is to be presented in the Council's report.

A resume of the report of the Committee on Federal Medical Services, Dr. Leon Higdon, Paducah, Chairman, is as follows:

Item 1. *Hometown Medical Care Program*

The Hometown Medical Care Program of the Veterans Administration was discussed with Dr. Oliver Miller of the Louisville V.A. office. Dr. Miller says this Program is very satisfactory, so far as the V.A. is concerned. He points out that services are to be provided only to those veterans with service-connected disability and not their dependents. A veteran with a medical emergency may be admitted to a local hospital for care, but if the V.A. is to assume the cost, the admission must be reported to their nearest office within seventy-two hours of the admission time. The fee schedule which is currently in effect seems to be satisfactory both to the Veterans Administration and our profession, and no changes are contemplated.

Item 2. *Outwood Conference* (TB Hospital, Dawson Springs, Kentucky)

Under this heading it is noted that there has been some effort apparently on the part of the V.A. to close the Outwood facility at Dawson Springs, and that certain individuals and groups of citizens in Dawson Springs had contacted the Veterans Administration, requesting an audience with them to which the President of KSMA was invited. The meeting occurred on April 1, 1960. The purpose of the meeting was to urge the V.A. to expand the facility rather than to contract it. Dr. Abell reported that at no time did the discussion enter an area where KSMA might have been of assistance. In view of this matter, no action is taken by this Committee, and no recommendation is made to the Council of KSMA.

Item 3. *Request of Daniel Bower, M.D., Williamsburg*

A letter from Dr. Daniel Bower, Williamsburg, Kentucky, referred by KSMA Council, relates the fact that optometrists and chiropractors are making a concerted effort to participate in the V. A. Hometown Medical Care Program, and he wishes KSMA, through its appropriate Committee, urge the V. A. to retain the status quo in this matter as it now stands. This Committee, however, preferred that the matter be referred to the Committee on Public Information and Service for disposition. A letter was sent to Dr. Bower thanking him for his interests.

Item 4. *Letter from General Accounting Office*

This concerns a communication from the General Accounting Office on the administration of Medicare Contract as it relates to members of KSMA. The G.A.O. found that the Administrative Agent is adequately discharging his duties but had two recommendations:

A. On the subject of physicians billing the government for Medicare services at the maximum Medicare allowance instead of their normal charge in those cases relating to persons with incomes of $4,500 or less, KSMA Editorial Staff is requested to publicize this matter in the KSMA Journal and other media.

B. The other point concerned payments made to state hospitals for services of resident physicians. In some instances Medicare received billing from the residents and also from the hospital. This matter of duplicate billing has already been resolved.

8. Other Items

Doctor Higdon reported he had received some material from the KSMA Headquarters Office concerning actions and recommendations taken at the AMA Interim meeting in Dallas, Texas in December of 1959. He called particular attention to Resolutions No. 20 and 24, which were adopted by the AMA delegates. These resolutions read as follows:

Resolution No. 20

WHEREAS, American Medicine has fought diligently against socialized medicine in this country; and

WHEREAS, Veterans' hospitals are so conducted that non-service connected patients, well able to pay for medical and hospital services, are accepted and often kept for excessive lengths of time; therefore be it

RESOLVED, by this House of Delegates that a strong protest be made to the heads of the Veterans' Administration urging stricter screening of non-service connected disability patients admitted to government hospitals; and be it further

RESOLVED, that copies of this resolution be furnished to the President of the United States, the Secretary of Defense, the Secretary of Health Education and Welfare, and interested members of Congress.

Resolution No. 24

WHEREAS, the medical profession of the United States feels a deep and abiding obligation to provide for the needs of veterans with service-connected disabilities and

WHEREAS, all replies to a recent communication addressed to all state medical societies (40 heard from as of December 1, 1959) indicate that they are in complete accord with the following sentiments:

(1) Limitation of Federal Medical Care of all veterans to service-connected disabilities.
(2) Provision for care of veterans with service-connected disabilities by the Armed Forces Hospitals and/or local civilian hospitals on a Hometown Care basis and/or U.S. Public Health Service Hospitals.

WHEREAS, the medical care of veterans, more than 85% of which is for non-service connected disabilities, now costs the taxpayers nearly a billion dollars a year—one fifth of the total Veterans Administration budget, and

WHEREAS, the general public is entirely unaware of this situation, and

WHEREAS, the only means to accomplish the

above mentioned objectives and enlighten the public is by a Congressional hearing which can only be obtained by the concerted action of State Societies and the American Medical Association, and

WHEREAS, the proper medium for doing this is the American Medical Association: therefore be it

RESOLVED, that the AMA House of Delegates instruct the appropriate Officers, Committee or Council to work towards obtaining a Congressional Hearing on this matter WITHOUT DELAY, and be it further

RESOLVED, that such appropriate Officer, Committee or Council call upon the Component Societies of the AMA for assistance and support.

It was moved that this committee approve the content of Resolutions Nos. 20 and 24, which were approved and adopted at the AMA Dallas Meeting and that (1) the KSMA Council be asked to instruct our AMA delegates to support any resolutions along this line which could again arise and (2) that the KSMA Council be asked to prepare a resolution in the same vein as Resolutions Nos. 20 and 24 for presentation to the 1960 KSMA meeting of the House of Delegates. The motion carried.

The other Associate Committees submitted no report.

Finally, I would like to express my appreciation to the members of the Committee on Education and Economics of KSMA for their efforts in behalf of the problems which we have considered. They have given freely of their time, effort and resources; and to the official family at KSMA Headquarters who have, as is their custom, labored continuously and constructively in their assistance to us.

Committee on Medical Education and Economics

Claude C. Waldrop, M.D., Williamstown
John Dickinson, M.D., Glasgow
O. Leon Higdon, M.D., Paducah
John Quertermous, M.D., Murray
Gaithel L. Simpson, M.D., Greenville, Chairman

Recommendations, Reference Committee No. 2

This report concerned itself with the problem of two years of general practice prior to specialization, relative fee value study, advisability of KSMA making some attempt to expose inferior medical insurance policies offered the public, the possibility of sponsoring a program pointing toward the establishment of nursing homes which would be loosely contiguous with many of the general hospitals in the state wherein services could be provided at a competitive figure and quality of care standardized.

The legislative committee has worked hard and effectively under the leadership of its chairman, Doctor Norvell and its Frankfort KSMA representative, Mr. Bob Grogan.

Item (1) on Hometown Medical Care and Item (2) Outwood Conference and other items were all noted and approved.

Mr. Speaker, I move the adoption and implementation of this section of the report. This motion was seconded and carried.

Report of the Medicare Review Committee

The Medicare Review hereby submits its Annual Report. This Committee has functioned very smoothly in the past year and the Chairman is deeply appreciative of the fine work done by the other members of this Committee.

While the exact number of records reviewed is not known, it is estimated that this Committee reviews approximately 350 cases a year.

On behalf of the Committee, as Chairman, I would like to express appreciation for the efficiency and wholehearted cooperation shown by the Headquarters Staff of the Kentucky State Medical Association.

Medicare Review Committee

McHenry Brewer, M.D., Louisville
Pat Imes, M.D., Louisville
Robert C. Long, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 2

The report of the Medicare Review Committee is approved. It is noted that they are reviewing approximately 350 cases per year.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of the Advisory Committee to the University of Kentucky Medical Center

On March 30, 1960, a meeting was held with Dean William R. Willard and four members of his staff, at which time detailed reports of the progress in construction of the new Medical Center was given. Also Doctor Willard discussed the plans for the recruitment of the teaching staff, the screening of applicants for the 1960 freshman class, and the progress and program of the medical library which is to serve the medical profession of the entire state.

Advisory Committee to University of Kentucky Medical Center

Harry Denham, M.D., Maysville
Byron Harrison, M.D., Owensboro
Delmas Clardy, M.D., Hopkinsville
Sam Overstreet, M.D., Louisville
Jesse Funk, M.D., Bowling Green
Branham Baughman, M.D., Frankfort
Carl Kumpe, M.D., Covington
Coleman C. Johnston, M.D., Lexington
Robert Strode, M.D., Winchester
Wendell Lyon, M.D., Ashland
Louise Caudill, M.D., Morehead
Paul B. Hall, M.D., Paintsville
Charles Stacy, M.D., Pineville
Charles Cawood, M.D., Middlesboro
Harold McPheeters, M.D., Frankfort
Russell Teague, M.D., Frankfort
C. C. Howard, M.D., Glasgow
Leon Higdon, M.D., Paducah, Chairman

Recommendations, Reference Committee No. 2

This report is short and concerned the progress of the new medical center in Lexington.

Mr. Speaker, I move the adoption of this section of the report.

Report of the Committee on Scientific Assembly and Arrangements

This Committee has only held one meeting this year in preparation for the Annual Meeting. The Committee does feel that the 1960 program will be of interest to all and hopes you will find it rewarding. We are grateful to Beverly Towery, M.D., for his efforts in assembling this program.

Arrangements for the 1960 Meeting are closely allied to that of prior meetings. There will be six specialty group meetings on Tuesday afternoon and then seven specialty group meetings on Thursday morning. As before, the KSMA will furnish visual aids for these groups with the responsibility of operation left to the various specialty groups.

Of particular importance to those serving on Reference Committees and for those testifying is that this

year's meetings will be held in the First Christian Church. These quarters are air conditioned, which should make for greater comfort.

We would want to express our appreciation to J. Thomas Giannini, M.D., Louisville, Chairman of the Associate Committee on Scientific Exhibits, for his efforts. All space is taken and the Committee feels that some outstanding exhibits (12) will be displayed.

The Associate Committee on Technical Exhibits, under the able leadership of John D. Allen, M.D., Lousiville, reports that all space for technical exhibits (65) was sold immediately after offering. This followed a 10% increase across the board in rental fees. Space was again allotted on the basis of the priority point system.

May we urge you to visit these exhibits, both technical and scientific, at every opportunity. Besides the personal gain you can garner from these visits, let us remember the financial contributions our exhibitors contribute to our Meeting.

Proudly we announce that, for the first time at any State Medical Association Meeting, a transatlantic clinical pathological conference will be presented. This transatlantic link will be held on Wednesday, following the President's Luncheon. Sponsored by the Smith, Kline and French laboratories, this first will feature a discussion between the British Medical Association and three KSMA members, plus a guest speaker at our meeting.

We feel that all of you will want to be in Columbia Auditorium at 2:00 p.m. Wednesday afternoon to listen to this unusual feature.

Under the direction of William C. Wolfe, M.D., Louisville, the KSMA Associate Committee on Golf has made arrangements to have this year's tournament at the Louisville Country Club.

The KSMA Associate Committee on Postgraduate Medical Education has met three times during the year and devoted considerable time and effort in its role to increase the facilities for postgraduate medical education in Kentucky. To Walter S. Coe, M.D., Louisville, Chairman of the Committee, may we express our gratitude for the time and energy he has expended in bringing this goal to fruition. Doctor Coe has given up much of his free time to further this cause. As you know, one of the purposes of the increased dues voted by the 1958 House of Delegates was to promote postgraduate education in Kentucky. To implement this goal, a postgraduate medical office was established. A summary of this fund and its operations is submitted below:

Establishment of Postgraduate Medical Office

The business year of the Postgraduate Medical Office started officially on July 1, 1959.

Friedrich Hertle was appointed as Executive Director of this office in December, 1959.

The office was opened March, 1960, at 104 West Chestnut Street, Louisville 2, Kentucky.

Activities Since Appointment of Executive Director and Establishment of Office

A. Objectives of Postgraduate Medical Education Office

The office was put in operation in order to organize, promote and coordinate postgraduate medical education in the State of Kentucky. Its function was based on the realization that the rapid growth and advancement of the medical sciences necessitate regular refresher courses and continuous medical education.

Thus it is the ultimate aim of this office to serve all physicians in Kentucky by presenting suitable programs of continuing education in addition to their own experience and reading. This service shall make it possible for each physician to use in his practice the modern medical knowledgement that continuously becomes available.

B. Compiling of General Information on Postgraduate Medical Education

The first step taken after this office was put in operation was to compile and evaluate all information on postgraduate education that was available. For this purpose a great number of similar existing institutions, medical schools, medical societies, etc., were contacted on a nation-wide basis.

C. Coordination of Programs

All medical institutions and societies in the State of Kentucky were contacted and invited for cooperation with this office. Purpose was to keep up continuously with dates of meetings and courses given by these organizations in order to avoid conflicts by programming our own courses. In this connection most medical institutions, universities and medical societies of states adjacent to Kentucky were also contacted to keep us informed of their activities. Purpose and aim is to create an overall integrated program to make it possible for physicians in Kentucky to participate in activities offered by other states at locations that might be closer than Louisville or Lexington.

D. Introduction of Postgraduate Medical Office

The activities of this office and its existence were announced in the KSMA Journal as well as by a personal letter and a statistical questionnaire sent to all physicians in the State of Kentucky.

E. Realization of Activities

After this planning period the first steps were taken in setting up scientific programs for the District Councilor Meetings in Kentucky. It included the securing of scientific speakers mostly faculty members of the University of Louisville Medical School and other physicians of Kentucky. Most programs were accepted for category I credit.

F. Publication of Programs

Since December 1959 the KSMA Journal reserved a page for publication of all postgraduate opportunities that were offered in Kentucky and adjacent states. These programs are being published three months in advance.

G. Clearing House for Speakers

Another major function of this office is its activity as a clearing house for scientific speakers. For this purpose a card system was started which was cross referenced according to specialty groups, topics of past presentations and speakers. This system will be extended on a nation-wide basis. Quality and success of speakers are included after contacting sponsor after such courses. Ultimate aim is to have qualified speakers in all fields ready for future events.

H. Non-Profit Organization Application

All necessary data and information were submitted with application for tax exemption. Mr. Rufer's services as C.P.A., the KSMA files on the McDowell Memorial Fund and the KSMA's accounting department were employed as references.

I. Financial Support by Industries

Several pharmaceutical companies were approached to support and sponsor postgraduate medical programs. Good cooperation and assistance were secured.

J. Other Financial Resources

Other institutions are to be contacted for financial support of this office. The Kentucky State Department of Health is one of several granting financial aid for various programs planned for fall 1960.

K. Postgraduate Medical Programs in Kentucky

The first postgraduate medical course to be held since the existence of this office was a

SYMPOSIUM ON SELECTED TOPICS ON GASTRO-INTESTINAL DISEASES. It was planned by the new Medical Center in Lexington, Kentucky under Dr. E. D. Pellegrino and Dr. W. R. Willard, and promoted and publicized by this office. Although this program was promoted on a short term notice, the attendance was surprisingly good — 70 doctors — and the quality of this course made it worthwhile to attend.

For fall 1960, there are about four courses in postgraduate medical education planned and being set up.

In Louisville we plan a two-day course on OB-GYN, and a 12-week course on ECG. Bowling Green will have a two-day course on CHRONIC DISEASE, which will be held at other locations as well as all over the State of Kentucky.

Other topics will be in various fields and specialities according to the statistical survey and its evaluation. (see paragraph D)

The ultimate aim in this respect is to bring our postgraduate opportunities out in the state to doctors at locations removed from the two medical centers.

L. Long Range Projects in Postgraduate Medical Education

1. It is hoped that during the year 1960-1961 the following tentative proposals can be realized:
   A complete coordination and integration of activities given and sponsored by the various groups and societies. This can only be accomplished however if every one will guarantee a dedicated cooperation in behalf of our efforts. Our part in this connection will be to call upon subject institutions and individuals again and again! Further to use more and different means of promotion than up to now. More personal contacts will be emphasized as well. For this reason experienced personnel of the University of Louisville Department for Adult Education was contacted for help and advice.
2. Full exploration of teaching facilities, cooperation of hospitals, staff members, faculty members, etc. Closed circuit television programs, tapes, films, slides, etc., are means to be explored and developed.
3. Main objective for the present time however remains to create a wider interest for our activities among physicians in the State of Kentucky as well as other societies and institutions as mentioned above.

Committee on Scientific Assembly and Arrangements

Frank L. Duncan, M.D., Monticello
Beverly T. Towery, M.D., Louisville
G. F. Brockman, M.D., Greenville
Richard G. Elliott, M.D., Lexington
John D. Allen, M.D., Louisville
John T. Giannini, M.D., Louisville
Irvin Abell, Jr., M.D., Louisville, Chairman

Recommendations, Reference Committee No. 2

We heartily endorse and commend the committee for all the work which is evident in our 1960 program and for the excellence of the scientific and technical exhibits.

We on the Reference Committee wish to thank the First Christian Church for the use of their quarters.

We feel that the establishment of a postgraduate medical education program in the state will be a big milestone in the progress of medicine in Kentucky.

We commend the committee on their initiative in obtaining the transatlantic CPC.

Mr. Speaker, I move the adoption and implementation of this section of the report. The motion was seconded and carried.

Report of the Committee on Allied Professions

Your Committee on Allied Professions submits the following report:

BLUE CROSS COMMITTEE, Sam A. Overstreet, M.D., Louisville, Chairman.

The formation of committees to investigate abuses of Blue Cross, as recommended by the 1959 House of Delegates, has been done in many hospitals throughout the state. It is hoped we will soon have these investigative units in all hospitals.

Letters of information and booklets of instruction were forwarded to all members of the Kentucky State Medical Association by this committee during the year.

DENTAL COMMITTEE, James S. Rich, M.D., Lexington, Chairman.

No meeting during the year.

HOSPITALS, Samuel H. Flowers, M.D., Middlesboro, Chairman.

No report and no meetings during the year. Dr. Flowers was recently forced to resign the chairmanship of this committee because of other obligations.

NURSES TRAINING, Henry B. Asman, M.D., Louisville, Chairman.

No actual meetings during the year. The chairman states there was nothing of importance to merit a full committee action. Dr. Irvin Abell and the chairman of this committee met with the executive secretary of the Kentucky Association of Registered Nurses concerning legislative matters on a national level.

PHARMACY, Michael R. Cronen, M.D., Louisville, Chairman.

Dr. Walter Coe and I were selected as delegates to the U.S.P. for 1960. We represented the Kentucky State Medical Association and the University of Louisville.

PUBLIC HEALTH, Delmas M. Clardy, M.D., Hopkinsville, Chairman.

Immunization was again promoted by this committee. The chairman reports its results are difficult to evaluate, probably because it is carried out in such a routine manner without the usual publicity and fanfare of previous years.

The committee feels that organized medicine should exert greater influence in an attempt to have all Kentucky public water supplies fluoridated.

We submitted editorials to the Journal concerning this subject and also Carcinoma of the Cervix. Considerable enthusiasm is evidenced by the committee in the progress being made in the earlier detection of carcinoma of the cervix. Carcinoma of the lung is felt to be definitely on the increase, but not much enthusiasm is being shown by the profession as a group to combat this disease.

It is felt that the prevention of highway accidents could be better dealt with, at least, from the standpoint of the medical profession, if an active committee dealing solely with this problem be appointed. We note that the American Medical Association and several states have such committees and feel they are making satisfactory progress.

The following recommendations are made by this committee:

That the Kentucky Medical Association support legislation in regard to compulsory immunization against Poliomyelitis, Tetanus, Diphtheria, and Pertussis.

SCHOOL HEALTH, Carroll L. Witten, M.D., Louisville, Chairman.

This committee has been quite active during the past year. It met, organized, and outlined a series of projects for this period of service. It has continued the activities with which it has been charged by the House of Delegates of the Kentucky State Medical Association concerning health of the school child.

For the second year this committee aided in setting up a conference on Athletic Injury Prevention, in cooperation with the Kentucky High School Athletic Association, the Kentucky Advisory School Health Council, and the University of Kentucky Athletic Association.

Committee on Allied Professions

Sam A. Overstreet, M.D., Louisville
James S. Rich, M.D., Lexington
Samuel H. Flowers, M.D., Middlesboro
Henry B. Asman, M.D., Louisville
Michael R. Cronen, M.D., Louisville
Delmas M. Clardy, M.D., Hopkinsville
Carroll L. Witten, M.D., Louisville
Charles M. Edelen, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 2

This report consisted of reports of the Advisory Committee on Blue Cross, Dental Committee, Committee on Hospitals, Committee on Nurses Training, Committee on Pharmacy, KSMA Advisory Committee on Public Health and the KSMA Advisory Committee on School Health.

This report was approved, except it was felt that the dental and public health committees might jointly exercise greater influence in securing fluoridation throughout all Kentucky.

We note the increase in carcinoma of the lung, but we disagree on the apparent lack of enthusiasm by our profession as a group to combat this disease.

We note that the KSMA has no active committee for the prevention of highway accidents and no suggestion for the appointment for such a committee was made. We feel like one should be appointed.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried.

Report of the Professional Relations Committee

It is a pleasure to report that the Professional Relations Committee did not have occasion to function during the past year. Any controversies which may have occurred were settled either at the County Society or Councilor District level and none were referred to this Committee.

Professional Relations Committee

Clyde C. Sparks, M.D., Ashland
Richard R. Slucher, M.D., Louisville
Edward B. Mersch, M.D., Covington
Robert W. Robertson, M.D., Paducah
J. Duffy Hancock, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 2

We are happy that the Professional Relations Committee did not have occasion to function during the past year.

Mr. Speaker, I move the adoption of this section of the report. Motion seconded and carried.

Mr. Speaker, I move the adoption of this report as a whole. Motion was seconded and carried.

Reference Committee No. 2

D. L. Graves, M.D., Frenchburg
Thurman Perry, M.D., Jenkins
Harold Eskind, M.D., Louisville
Kenneth Crawford, M.D., Louisville
B. J. Baute, M.D., Lebanon, Chairman

Resolution C—Committee on Medical Education and Economics

Introduced by: Committee on Medical Education and Economics

Subject: Veterans Affairs "KSMA Delegates to AMA"

WHEREAS, the medical profession of the KSMA feels a deep and abiding obligation to provide for the needs of veterans with service connected disabilities, and

WHEREAS, all replies to a recent communication from the AMA addressed to all State medical societies indicated that they are in complete accord with the following sentiments:

(1) Limitation of Federal Medical Care of all veterans to service-connected disabilities.

(2) Provision for care of veterans with service-connected disabilities by the Armed Forces Hospitals and/or local civilian hospitals on a Hometown Care basis and/or U. S. Public Health Service Hospitals.

WHEREAS, the medical care of veterans, more than 85% of which is for non-service-connected disabilities, now costs the taxpayers nearly a billion dollars a year—one fifth of the total Veterans Administration budget, and

WHEREAS, the general public is entirely unaware of this situation, and

WHEREAS, the only means to accomplish the above mentioned objectives and enlighten the public is by a Congressional hearing which can only be obtained by the concerted action of State Societies and the American Medical Association, and

WHEREAS, the proper medium for doing this is the American Medical Association; therefore be it

RESOLVED, That the KSMA House of Delegates instruct the appropriate Officers, Committee or Council to work towards obtaining a Congressional Hearing on this matter WITHOUT DELAY.

Resolution D—Committee on Medical Education and Economics

Introduced by: Committee on Medical Education and Economics

Subject: Veterans Affairs

WHEREAS, American Medicine has fought diligently against socialized medicine in this country; and

WHEREAS, Veterans' hospitals are so conducted that non-service-connected patients, well able to pay for medical and hospital services, are accepted and often kept for excessive lengths of time; therefore be it

RESOLVED, by this House of Delegates that a strong protest be made to the heads of the Veterans' Administration urging more strict screening of non-service-connected disability patients admitted to government hospitals; and be it further

RESOLVED, that copies of this resolution be furnished to the President of the United States, the Secretary of Defense, the Secretary of Health Education and Welfare, and interested members of Congress.

Recommendations, Reference Committee No. 2

Resolutions 20 (D) and 24 (C) are deemed in order. We wish to commend the work of the Committee on Medical Education and Economics for their efforts in behalf of all the problems which they have considered.

Mr. Speaker, I move the adoption and implementation of this section of the report. Motion was seconded and carried.

REFERENCE COMMITTEE NO. 3

Loman C. Trover, M.D., Chairman

Reports on Legislation and Public Relations

Report of the Committee on Public Information and Service

There have been two meetings of the Committee on Public Information and Service, both of which were held at the Campbell House in Lexington, Kentucky, in December, 1959, and June, 1960. Some of the main topics discussed were as follows:

AAPS Essay Contest: Only three counties out of the entire State had entries in the 1959 AAPS Essay Contest, which indicated a very definite lack of interest. It was the feeling of this committee that the essay contest should not be sponsored by the KSMA in 1960.

Exhibits — Kentucky State Fair — KEA: It was reported to this committee by Mr. Rudd that the exhibit "Nutrition Nonsense and False Claims" was scheduled for the 1960 KEA meeting and that the new AMA exhibit "The Transparent Woman" was tentatively booked for the Kentucky State Fair, September 9 through 17th. This committee then instructed the KSMA Headquarters Office to secure the best exhibits for the KEA meeting and 1960 State Fair.

Doctors' Secretary Course: A Doctors' Secretary Course directed to secretaries, receptionists, assistants or nurses had been sponsored and held by KSMA some years ago. The KSMA Headquarters Office had recently been requested to repeat this course. The original course consisted of three nights on public relations and one night to Blue Shield-Blue Cross matters. The purpose of this course was to acquaint the various doctors' assistants along the lines of better public relations and to improve their efficiency. It was recommended to the KSMA Council that a "Doctors' Secretary Course" be again sponsored by the KSMA on whatever basis deemed necessary and a time convenient to the Director of Field Services. Along the same lines it was noted that the AMA had a new film titled "First Contact" which could be made available for use in this course. (This recommendation was approved by the Council).

Membership Applications in County Societies: The County Societies requested the KSMA Headquarters Office to prepare an application form for all physicians applying for membership in the county society. A rough draft of this form was reviewed by the committee and the committee felt that it was adequate in every respect and made the recommendation that the KSMA Council endorse this form and also recommended that a letter be sent to all county society secretaries informing them that these forms were available upon request. (This recommendation was approved by the Council).

Guide for County Society Presidents: A list of recommendations for County Society Presidents was reviewed by this committee and it recommended that they be mimeographed and sent to all County Society Presidents from the Headquarters Office of the KSMA pending approval of the KSMA Council. (This recommendation was approved by the KSMA Council).

Questionnaire on Free Time Donated by Physicians (medical care, charitable dollars, etc.): Several questionnaires on the amount of free time given by various physicians in various parts of the country were reviewed. This committee recommended to the KSMA Council that a survey be conducted (based on the form used by South Dakota) and that the information obtained from this survey may well be used as a state-wide news release. (This recommendation was not approved by the KSMA Council).

Practical Nurse Training Program in Kentucky: A letter was read to the committee from Mr. James L. Patton, Director of Social Education, Frankfort, requesting the KSMA to assist and endorse the proposed expansion budget for the Practical Nurse Program in Kentucky. Mr. Patton further requested and thought it would be helpful if the KSMA would write a letter to the Governor of Kentucky asking that the proposed expanded budget be considered with copies of the letter going to the Commissioner of Finance and Superintendent of Public Instruction. This letter could also point out the feasibility of changing the policy of the Budget Division only approving funds for programs that are operating under the supervision of state operated vocational schools or State hospitals. The committee therefore requested that the KSMA Council give consideration to writing a letter such as Mr. Patton has proposed and that this letter be mailed over the signature of the KSMA President. (This recommendation was approved by the KSMA Council).

Professional Relations Committee report to House of Delegates: In 1959 the House of Delegates requested that a report of the Public Relations Committee be forwarded to the Committee on Public Information and Service for study. It was felt by this committee that grievance matters could be adequately handled on three levels; viz., the county, councilor and state. Therefore, no action was taken.

KSMA Advisory Committee to Blue Shield Report to House of Delegates: The Executive Committee at its meeting October 22, 1959, requested that this committee inform all physicians in Kentucky of the action of the House of Delegates stressing the necessity of listing their total fees for services rendered on the claim forms submitted to the Kentucky Physicians Mutual. Inasmuch as the letter was going to all the physicians in Kentucky from the President, informing them of this request, it was decided by this committee to also disseminate this information through News Caps.

Blue Shield Matter: The Chairman then read a letter from Mr. Ed McConnell, Vice President, Blue Cross, in which an advertising firm in an attempt to secure the Blue Cross-Blue Shield account had conducted a brief survey on their own. Among other things, the survey showed that a large majority of the people questioned were of the opinion that if a physician knew his patient was a member of Blue Shield, then that physician would double his fee. The net result in the public's eye was that the patient still had to pay the same fee to the physician and that the physician also collected from Blue Shield. After a lengthy discussion, the committee was of the opinion that this image was not in the mind of the majority of the people; that only a very, very small percentage of physicians would resort to such practices and that this was mostly a selling device used by the advertising and public relations firm in trying to secure this account. It was also felt that an advertising campaign such as recommended by the advertising firm would probably get people to thinking that this is a widespread problem and call unjust attention to this practice. By common consent, the letter was noted for informational purpose only and that no action be officially taken by this committee.

Blue Shield-Blue Cross-KSMA Dinner for Residents and Interns: The KSMA and Blue Shield-Blue Cross are making plans for a dinner meeting of all interns and residents throughout the State as an orientation procedure for these physicians before they enter into the actual practice of medicine to acquaint them with the inter-workings of these three organizations. This committee endorsed this plan wholeheartedly.

Use of M.D. Designation: This committee again felt that the use of M.D. after the physician's name rather than the "Dr." before the name should be again brought to the attention of the Kentucky doctors through the medium of News Caps, which was done in the January, 1960 issue.

Confusion in Blue Shield Contract: This committee also voted to recommend to the Council that proper steps be taken to disseminate information to both the doctor and/or patient in regard to the medical rider on Blue Shield post-operative coverage. The committee was of the opinion that much confusion exists as to what medical condition should exist for the medical rider to cover the post-operative period such as diabetes, heart diseases, etc.

Report on Senior Day: A brief review of the 1960 Senior Day Program was given. It was the feeling of this committee that the main speaker for the evening session should be chosen for his ability to deliver an inspirational type of message which is geared to the medical profession.

The 1961 Senior Day Program was tentatively scheduled for March 20, and it was felt by this committee that some effort should be made to record the entire procedure on tape to be used by future participants for their information. In addition it was the feeling of this committee that questionnaires be sent out to all members of the 1960 Senior Medical Class asking them for their reactions and comments to the 1960 program. These replies would be summarized and sent to all members of the committee on Public Information and Service.

Plans for 1960 New Members Luncheon: This was discussed and it was the recommendation of this committee that the same general outline should be followed in the 1960 luncheon as was followed last year. In addition, the same participants would be again asked to participate. Thirty-three (33) new members attended this luncheon in 1959.

Practical Politics Course: A discussion then centered on the practical politics courses that have been held in various parts of Kentucky. Some of these courses have been presented by the Chamber of Commerce, labor unions, management and other interested organizations. Doctor Dyer reported that he had attended such a course in Louisville and that this course is primarily to get people interested in politics and that, in his opinion, a course such as this is very worth while.

The Committee discussed the idea of having a course on practical politics for physicians only, which perhaps could be presented on a councilor district basis or a smaller grouping, with the idea that this course could be so organized by the Kentucky State Medical Association and presented by some one in the KSMA Headquarters Office. It was suggested that perhaps a good time to hold these courses would be in the winter when the physicians might not be quite so busy or be on vacations, etc. It was taken by common consent that this idea be brought to the attention of the KSMA Council and that a packet containing information and questions that participants use to take this course also be shown to the Council and that Doctor Dyer be present to discuss this request to the Council, inasmuch as Doctor Dyer is familiar with the course.

Daniel Bower, M.D., Williamsburg request: Doctor Bosworth then related that Doctor Bower, who serves as Department surgeon for the American Legion, had written the Association relative to steps he felt should be taken in respect to the action of Optometrists and Chiropractors in their insistence to get the VA to accept their service and pay for these services under the Home Town Medical Care Program. Doctor Bower is seeking support from the profession to resist these efforts. He feels the KSMA membership should become more active in VA affairs and at the same time to be aware of various pressure steps being taken in these groups.

Doctor Bower's request had originally gone to the Legislative Committee; then to the KSMA Council; and then to the Committee on Federal Medical Services. The Committee on Federal Medical Services recommended that this matter be referred to the Committee on Public Information and Service, as recommended by the Council, and that they be alert to the problem and to do what they think best in publicizing this issue. By common consent, the Committee agreed that a notice should be put in News Caps, asking all physicians belonging to Veterans groups in Kentucky to be alert to the demands that the Chiropractors and Optometrists are making in their efforts to get recognition and payment from the Veterans Administration. It was suggested that this article mention that this is a good way to protect the patient and public from abuse or wrong medical practices.

WHAS Radio Program: Mr. Rudd related that WHAS radio had asked the Kentucky State Medical Association to furnish a physician to take part in a radio program called "Your Health." This program in the past had been presented with the cooperation of the Public Health Department. However, this Department has recently moved to Frankfort, which makes it somewhat more difficult for it to carry on the main part of the program. WHAS radio is interested in getting a physician of the Kentucky State Medical Association to contribute around ten minutes to the discussion and perhaps have some one from the Public Health Department to take up the remaining five minutes of each fifteen minute program. The idea of the Kentucky State Medical Association taking part in such a program was presented to the KSMA Council at its May 26 meeting and the Council referred this matter to this Committee. The Committee was informed that John A. Bishop, M.D., Jeffersontown, had agreed to serve as the Kentucky State Medical Association physician on this program. The Committee was of the opinion that Doctor Bishop was a very good choice for a part such as this.

However, it was suggested that WHAS radio station be approached on the idea of not mentioning the participating physician's name, only noting that a qualified physician is appearing on this program, representing the Kentucky State Medical Association. It was felt this could perhaps save the participating physician from any criticism by his colleagues and at the same time would not give him the benefit of having his name continuously being placed before the public.

American Medical Assistants Association: This is a national organization composed of medical secretaries, office nurses and other doctors' assistants, with chapters in various states. This organization has been officially recognized and approved by the AMA but has never received endorsement from the KSMA. There is presently one chapter in Kentucky; the Jefferson County Chapter.

Some time ago the AMAA requested that the KSMA officially recognize the AMAA in Kentucky as an organization (official recognition by KSMA would give the AMAA more "status," which could make it easier to get other chapters organized in Kentucky). The Council referred this request to this committee for study before any action be taken. This committee met on two occasions and discussed this matter and at the second meeting studied the bylaws and constitution of the AMAA. After discussing the "pros" and "cons" it was recommended to the KSMA Council that the organization known as the AMAA be officially recognized by the KSMA. No action was taken by the Council other than refer this item back to the Committee on Public Information and Service for further study.

At the third meeting of this committee no action

was taken except to pass the request of the AMAA for KSMA recognition on to the House of Delegates for its consideration.

Committee on Public Information and Service

Carl Cooper, Jr., M.D., Bedford
Donald K. Dudderar, M.D., Newport
Robert S. Dyer, M.D., Louisville
Jesse Funk, M.D., Bowling Green
N. L. Bosworth, M.D., Lexington, Chairman

Recommendations, Reference Committee No. 3

Our Committee considered the Report on Public Information and Service and wish to approve the Report with the exception of the section concerning the American Medical Assistants Association. It is the feeling of the Committee that this proposed Association deserves the full consideration of the KSMA, but, due to the lack of pertinent information, feel that further study is indicated.

Mr. Speaker, I move the adoption of this section of the Report. The motion was seconded and carried.

Report of the Committee on Legislation

State Level

The KSMA Legislative Committee was co-chairmaned by George Archer, M.D., Prestonsburg, Chairman, National Affairs, and Wyatt Norvell, M.D., New Castle, Chairman, State Affairs. This report will concern activities in State Legislative Affairs.

The Legislature met in 1960 with a new executive, many new faces in the House (and a stepped up KSMA Legislative Program). New friends were made for organized medicine during the 60-day Legislature. Both representatives and senators expressed the opinion that organized medicine had proven that it could be "for something" instead of "against something." Bills presented which involved health or medical conditions were screened by our Lobbyist with the advice of your State Chairman together with members of the Legislative Committee.

The Legislative Committee worked under the "Key-Man" System with the State divided into Eight Congressional Districts with a District Key-Man in each District.

Each individual district was divided into sub-district key-man areas with a physician responsible for directing activities and information to a physician in each individual county in his sub-congressional district.

This Key-Man System has proved its worth if each physician involved does his duties. In some areas physicians failed to do the work necessary to present medicine's position in certain contacts necessary to get their senator or representative to support a bill which would be a good act and oppose any bill which would not be conducive to good health for Kentucky citizens.

The following is a resume of the three bills that KSMA introduced in the 1960 Legislative Session.

1. The Medical Care for Indigent Persons Bill which was approved by this Committee went through without too much difficulty because it was made a part of the Governor's Re-Organization Bill.

2. The Anti Quick Cremation Bill passed after picking up a simple amendment at the insistence of the Public Health Department.

3. The Anti Cancer Quackery Bill passed after meeting strong opposition from the chiropractors.

There were 285 bills introduced in the Senate and 39 of these had medical implication. Nineteen of the 39 passed the Senate. In the House 547 bills were introduced, 64 with medical implication. Twenty-seven of the 64 passed the House. Nineteen bills with related interest were introduced in the Senate and 20 in the House. There were also 73 Senate Resolutions and 142 House Resolutions introduced.

The State Legislative Affairs Chairman wishes to make the following recommendations for the 1960 House of Delegates. Direct the Council to:

1. Recommend that each specialty group appoint two physicians to check any bills with medical implication involving their specialty.
2. Give thorough study to the KSMA Key-Man System to strengthen the activities at all levels of the Key-Man System.
3. Ask that the Congressional District Key-Men be members of the Legislative Committee.

It was felt that contact during the 1960 Legislative Session had been smoother and better co-ordinated than ever before and that the "Key-Man System" should be continued in operation.

Associate Committee to Study Medical Examiner System

The Associate Committee to Study Medical Examiner System has not had any meetings this year, but session of the Kentucky Society of Pathologists has been devoted to the question and numerous conferences have been held. Our feelings are the same as they have been in the past—that is, until there is a possibility of constitutional change in the State of Kentucky we will have a Coroner System. Our feeling has been that what we need is a means of giving the Coroner something to work with, be these Coroners, physicians, or lay Coroners; and that if funds from a state level are available for autopsy examinations and when indicated toxicologic examinations, many Coroners can perform in a much more creditable fashion than they do now. If we sought any change in legislation along this line, our suggestion would be as it has been in the past that one would set up legislation to the effect that a Coroner could succeed himself as long as he might seek to succeed himself—but in the case of a retiring Coroner not seeking re-election, then he could be replaced only by a physician. This, of course, would necessitate our selling young physicians over the State on the idea of endeavoring to carry on the job of Coroner. Actually, I think that with adequate help many lay Coroners could perform quite well, and it removes the bugaboo of a great deal of paper work to which many physicians are quite allergic.

(This report submitted by Malcolm L. Barnes, M.D., Chairman of the Associate Committee to Study Medical Examiner System, which is an associate committee of the Committee on Legislation.)

Wyatt Norvell, M.D., Chairman
State Affairs

Recommendations, Reference Committee No. 3

Our Committee considered the excellent report of the Legislative Committee for State Affairs and wishes to commend Doctor Wyatt Norvell for his persistent and productive efforts. This Report was approved in its entirety.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Which includes the three specific recommendations found above.) The motion was seconded and carried.

National Level

First, I want to thank the members of KSMA for the opportunity to serve in this capacity. This year has been very interesting, confusing, enlightening, to say the least. The Legislative battles in Washington have been fast and furious. The whole complexion has changed over night on many issues. This explains the many telephone calls, telegrams, letters, and Legislative Bulletins that have been sent to ask you to support yourself in political action. At times we have grown discouraged with our efforts. However, we can always ponder what would have been the

outcome if we had sat idly by and done nothing at all.

In attempting to fill you in at this late date, (this was written during the middle of August) with Congress still in session, the information may well have become history.

This 86th Congress has introduced 19,552 bills, of which 739 have had medical interest. The AMA has made 40 statements on 25 bills, which have been directed at medicine. Twenty-six of the statements have been in favor of the Legislation, 6 statements have been in opposition and 8 statements have been filed for information only. The main bills that we have supported are:

1. Tax relief for medical care for those over 65. This bill has passed and been signed into law.

2. H. R. 10—Keogh-Simpson Bill. The Bill has passed the House and the Senate Finance Committee. It is being opposed by "Northern Liberals"—outcome is uncertain at this time.

3. Social Security Coverage for Physicians—We have been successful in the Senate Finance Committee by a vote of 11 to 4 to not have physicians included. In our opinion, this will stay this way for this session.

4. Health Insurance Program for Retired Employees—Advocated.

5. Federal Guaranteed Mortgages, Loans for Nurssing Homes Expansion—This Bill has been passed.

6. Bill Sponsoring International Research—Passed and 50 million appropriated.

7. Forand Type Legislation—Although several bills have been proposed, the one that comes the nearest complying with the wishes of the AMA, in the Miami Session 1960, is the Mills Bill, H.R. 12580, Title VI. As of this date we have won support in the Senate Finance Committee by a vote of 10 to 7.

The way in which the platforms texts of the health planks of both political parties differ is:

The generally worded Republican platform differs from the Democratic program mainly in that it would apparently not use the Social Security System and would be voluntary. In addition, the G.O.P. Plan to Finance Health Care for the elderly would cover, "the aged needing it," rather than all elderly persons. It also calls for State participation, and for protecting the personal relationship of patient and physician.

Medicine's Position now is:

(1) Give all out support to the Legislative Bill for care of the aged that is based on "need of the patient."

(2) Political Action: While the influence and prestige of the doctors as individuals with their patients and public have been great, the medical profession as a whole has not been able to exert its full influence in the field of Legislation. In part, this has been due to the average doctor's reluctance to engage in political activity. In greater part, it is due to his failure to realize that the future of the practice of medicine may depend upon Congress and the various state legislatures. It is the duty, therefore, of all of us to alert our colleagues to the dangers threatening them and somehow to motivate them to take more interest in legislative activities. It will take the combined efforts of the entire medical profession, pulling together as a team to head off the "creeping paralysis of Socialism," which is seeking to engulf us through the use of Legislative Process.

We must form a *"Physicians League for Political Action"* and begin now to participate in grass roots activities by attending local precinct meetings, and finding out what candidates for office stand for. Not whether they are Democrats or Republicans, but what kind of Democrats and what kind of Republicans. This league should be supported with our *money* and personal efforts.

We must continue the use of our *Legislative Key-Man System.* However, more time and effort must be spent to see that the Key-Men are informed and trained. In my opinion, a "special breakfast" sponsored by KSMA at each State Meeting would add greatly to the "Esprit De Corps" of this unit of our State Association.

We must continue and expand the *Legislative Dinners in Washington* for our Congressmen and Senators, their wives and staff. We should plan toward the time when the same plan is used at the *State Level.*

We must expand our liaison and cooperation with our friends. The Allied Forces, to name a few are:

(1) Kentucky Dental Association

(2) Kentucky State Association of Registered Nurses

(3) Kentucky Pharmaceutical Association

(4) Kentucky Hospital Association

(5) Chamber of Commerce

(6) Farm Bureau

(7) Health Insurance Council of America

This is necessary because the men in politics of today are only interested in having our organization do two things for them—to give our money and to lend our voting strength. Of the two, they are more interested in our ability to "deliver the votes."

Therefore, we must support our Local Political Organization, give money to our Local County Chairman, and participate as citizens in a political group of our own choice, and always be identified with the Regular Party Organization.

Committee on Legislation

Branham B. Baughman, M.D., Frankfort
Willard Buttermore, M.D., Corbin
William B. Cartmell, M.D., Maysville
Delmas M. Clardy, M.D., Hopkinsville
Arnold B. Combs, M.D., Lexington
Marcus Coyle, M.D., Springfield
J. Duffy Hancock, M.D., Louisville
O. Leon Higdon, M.D., Paducah
C. C. Howard, M.D., Glasgow
Billy K. Keller, M.D., Louisville
Thomas P. Leonard, M.D., Frankfort
Joseph H. Liebman, M.D., Frankfort
G. David McClure, M.D., Louisville
Thomas McElhinney, M.D., Covington
John Quertermous, M.D., Murray
Robert Shepard, M.D., Lexington
Charles B. Stacy, M.D., Pineville
Hays Threlkel, M.D., Owensboro
L. O. Toomey, M.D., Bowling Green
Robert B. Warfield, M.D., Lexington

Wyatt Norvell, M.D., New Castle, Chairman State Affairs

George Archer, M.D., Prestonsburg, Chairman National Affairs

Recommendations, Reference Committee No. 3

The Legislative Committee at a National Level was considered at length. Here again we wish to commend the diligent efforts of the Chairman for National Affairs, Doctor George Archer. Our Reference Committee approves this report with the following recommendations:

1. Our Committee recommends that the House of Delegates instruct the Headquarters staff to obtain copies of the Bill for Tax Relief for Medical Care for those over 65 and see that copies be contained in our news letter.

2. We recommend and encourage the formation of a "Physicians League for Political Action" outside the framework of the KSMA.

Mr. Speaker, I move the adoption and implementation of this section of the report. The motion was seconded and carried.

Report of the KSMA Committee On Third Party Medicine

Your Committee on Third Party Medicine was asked to re-study its report to the 1959 session of the House of Delegates relative to the suggestion that a law be enacted known as "A Professional Practices Act."

The 1959 session of the House of Delegates, after studying the Committee's recommendation, felt that more consideration should be given to the problem.

After much discussion, it was taken by common consent that, in order to implement and carry out the mandate of the 1959 House of Delegates with respect to the report of the Committee on Third Party Medicine, Mr. Bobbie Grogan would obtain a list of the licensed professional groups in Kentucky (those having at least college degrees), the names of their officers, and the dates, if any, of their annual meetings, from which the committee would select the professions it feels might be interested in joining with the Association in promoting a professional practices act. The Committee would then draft a letter to discuss the matter further with representatives of this Association.

Resolution K

The next major item that the Committee considered was a referral from the Executive Committee of the Council. It relates to what was known as Resolution K, introduced at the 1959 session of the House of Delegates and having to do with suggestions relative to the practice of medicine in hospitals.

The House of Delegates asked each of the three specialty groups—anesthesiology, radiology, and pathology—to study Resolution K and report back to the Council.

The replies of these three groups to the Council were considered by the Executive Committee of the Council and referred to the Committee on Third-Party Medicine for their consideration and recommendation.

After much discussion, the following motion was passed: "It appears from the responses of the three specialty groups, (anesthesiologists, pathologists, and radiologists) that it is not expedient at this time for the Association to undertake to solve these problems by litigation." The Committee recommended to the Council that the possibility of sponsoring a professional practice act (as previously recommended by Past President Mersch) be further explored. The action of the Council of KSMA on this recommendation will appear in the Council's report to the House of Delegates under the section entitled "July 28 Open Meeting."

Your Committee also recommends that the House of Delegates ask the 1960-61 Committee on Third Party Medicine to study and attempt the formulation of a statement on the terms and conditions under which a physician may ethically accept salaried employment.

Committee on Third Party Medicine
Edward B. Mersch, M.D.
Carlisle Morse, M.D.
Richard R. Slucher, M.D.
Clyde C. Sparks, M.D.
Robert W. Robertson, M.D., Chairman

Recommendations, Reference Committee No. 3

The report on Third Party Medicine was considered and approved.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

The McDowell Home Committee Report

The McDowell Home Committee reports that the home, apothecary shop and grounds are in excellent condition and that the number of visitors has increased greatly during the year July 1, 1959 to June 30, 1960. At a recent meeting of the committee, plans were made to raise the annual budget to $6,000.00 and ways of increasing the income were discussed. The minutes of the meeting of this committee show the receipts and disbursements for the year and outline plans for the future.
(Secretary's Note—The digest of proceedings for the committee meeting held on August 4, 1960 is submitted below at the request of the Chairman.)

The McDowell Home Committee met for lunch at the Beaumont Inn in Harrodsburg, Kentucky, at 12:30 P.M. August 4, 1960. The following members of the committee were present: Drs. Charles A. Vance and Francis M. Massie, Co-Chairmen, Lexington; Dr. David Kinnaird, Louisville; Dr. George McClure, Danville; Mr. George Grider, Danville; and Mr. Sterling Coke, Lexington. The committee was pleased to welcome Mrs. Charles A. Vance at the meeting. Absent: Drs. Abell, Gray, Higdon, E. M. Howard, Gaithel L. Simpson and Dean Slone.

The agenda for discussion was:

1. Consideration of the financial statement for the year ending June 30, 1960 (copy enclosed). The committee noted with concern that the expenditures exceeded the receipts by $877.74. The balance on hand is $1,639.33, due to the fact that the balance on hand on July 1, 1959 (one year ago) was $2,517.07. The items of expense were discussed in detail and the only one, and incidentally the largest item, which could be reduced during the current year is $1,273.37 spent on publicity, brochures, pamphlets, etc., in connection with the dedication of the Apothecary Shop and acknowledgements of the McDowell Commemorative Stamp.

2. The committee thought receipts could be increased by increasing the number of admissions at the door. During the 12 months passed this totaled $1,435.98. It was thought this might be done by Luncheon Club talks showing slides of the Home and Apothecary Shop, before and after the restorations, and by requests to various surgical societies. It was gratefully noted that the Southern Surgical Association has for the past several years sent $200.00 annually for the maintenance of the Home. The co-chairman (Francis M. Massie) expressed the hope and belief that this gift would be continued annually. Other surgical organizations to whom requests for assistance should be made are the Kentucky Chapter of the American College of Surgeons, the Kentucky Society of Obstetrics and Gynecology, the Southeastern Surgical Congress, the American Society of Obstetrics and Gynecology and the American Gynecological Society. The committee voted to establish and work for an annual budget of $6,000.00. It was further agreed to request the Pharmaceutical manufacturers for annual contributions.

3. A report on the Apothecary Shop restoration was made by Mr. George Grider of Danville and Mr. Sterling Coke of Lexington. Mr. Grider noted that we now have as many pharmacy antiques as we can display. Mr. Grider was appointed Curator of the McDowell Home and Apothecary Shop property and authorized to undertake expenses and approve bills submitted by local tradesmen. Mr. Coke submitted the report of receipts and disbursements of the McDowell Apothecary Restoration Committee and noted that this committee has a balance of $684.51. It was decided that this balance could be used only for the Apothecary Shop under the terms of the gift of Eli Lilly. The financial statement of the Apothecary Restoration Committee, prepared by Yeager, Ford and Warren, was approved and ordered filed with the KSMA.

4. The McDowell Home Committee asked Dr. Kinnaird to consult committeeman, Dr. Laman Gray, in asking for contributions from obstetrical and gynecological societies.

The Co-chairman (Francis M. Massie) said that he would talk with the officers of the KSMA about putting a sentence advertising the McDowell Home on all official stationery.

The committee approved of inviting groups of school children to visit the Home, explaining that the admission fee would be charged.

The committee disapproved renting the property for social gatherings.

The committee notes with pleasure and pride the condition of the Home, Shop and grounds and takes this occasion to thank the hostess, Miss Crawford, for her interest and gracious reception of the public.

McDowell Home Committee

Irvin Abell, Jr., M.D., Louisville
Laman Gray, M.D., Louisville
O. Leon Higdon, M.D., Paducah
E. M. Howard, M.D., Harlan
George M. McClure, M.D., Danville
Gaithel L. Simpson, M.D., Greenville
Dean Earl P. Slone, Lexington
David W. Kinnaird, M.D., Louisville
Mr. George Grider, Danville
Mr. Sterling Coke, Lexington
Charles A. Vance, M.D., Lexington, Co-chairman
Francis M. Massie, M.D., Lexington, Co-chairman

Recommendations, Reference Committee No. 3

We note with satisfaction the continued interest in the historical McDowell Home and wish to commend this Committee on its efforts in its behalf.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

McDowell Fund
Kentucky State Medical Association

Receipts and Disbursements, July 1, 1959—June 30, 1960

Receipts:			
Balance Forward, July 1, 1959		$2,517.07	
KSMA Appropriation	$1,500.00		
Kentucky Surgical Society Contribution	1,000.00		
Southern Surgical Association Donation	200.00		
Committee for McDowell Stamp Issue	435.43		
Admission, Sales of Cards, Etc.	1,435.98		
Miscellaneous Donations	154.25		
Total Receipts, July 1, 1959—June 30, 1960		4,725.66	
Total Available Receipts			$7,242.73
Disbursements:			
Furnishings	$ 94.95		
Repairs to Home	383.70		
Salary—Hostess	1,216.00		
Insurance	527.43		
Supplies	167.31		
Publicity	1,273.37		
Gas and Electricity	535.08		
Miscellaneous Services	1,249.56		
Pay Roll Taxes	56.00		
McDowell Committee Expense	100.00		
Total Disbursements			5,603.40
Balance on Hand, June 30, 1960			$1,639.33

Balances in Various Accounts as of June 30, 1960

Furniture Account—Regular	$ 62.12	
Furniture Account—Woman's Auxiliary to Jefferson County Medical Society	48.65	
Furniture for Office	2.56	
Repairs, Supplies and Services	1,501.00	
Upkeep and Repair—Colonial Dames Room	25.00	
Total of Balances in all Accounts as of June 30, 1960		$1,639.33

Resolution A—Council of the Kentucky State Medical Association

WHEREAS the House of Delegates of the Kentucky State Medical Association, in session September 23, 1959, went on record in support of a constitutional change; and

WHEREAS when Governor Bert T. Combs took office as Governor in December of 1959 he was able to call a special session of the 1958 Legislature and take the first step in calling a limited Constitutional Convention, as provided in our State Constitution; and

WHEREAS the Legislature at its 1960 session voted to take the second step and place the holding of a limited Constitutional Convention on the ballot for the voters to approve at the general election on November 8; and

WHEREAS the next step in the procedure under the Constitution is for the people of Kentucky to vote for a Constitutional Convention during the general election, now therefore be it

RESOLVED, That the Kentucky State Medical Association urge every member, his family and employees to vote for the calling of a Constitutional Convention in the November election, and be it further

RESOLVED, That members of the Association, the members of their families and employees be urged to identify themselves with local existing organizations dedicated to supporting the calling of a Constitutional Convention and to getting out the vote on November 8.

Resolution E—Jefferson County Medical Society

From: Doctor Everett Baker, M.D., Chairman of the Delegates from Jefferson County

Subject: Support of the Limited Constitutional Convention and the Better Roads and Parks Bond

At the September 9, 1960 meeting of the Board of Governors of the Jefferson County Medical Society the following Resolution was duly adopted. The Resolution was also acted upon favorably by the Delegates from Jefferson County at their meeting on September 16, 1960.

WHEREAS, The Delegates of the Jefferson County Medical Society in September, 1959, recommended that a Constitutional Convention be called to revise our State Constitution, and

WHEREAS, similar action was taken by the Kentucky State Medical Association in its Annual Convention in 1959, and

WHEREAS, necessary legislative action has been taken to place before the people on November 8, 1960, the issue of whether or not a limited Constitutional Convention shall be called, which proposal has been endorsed by most prominent statewide organizations, and

WHEREAS, the Legislature has taken action submitting to the voters of this Commonwealth a referendum on a $100,000,000 Highway and Parks Improvement Bond Issue, and

WHEREAS, it is the opinion of this House of Delegates that the above-mentioned Highway and Parks Bond Issue should be approved by the people; Now Therefore,

BE IT RESOLVED by the Kentucky State Medical Association

1. That we heartily endorse both the Limited Constitutional Convention proposal and the Parks and Highway Improvement Bond proposal;
2. That we urge all the members of the Kentucky State Medical Association to endorse this action of the Board, and

3. That each member of this Association both work and vote for the passage of these two issues.

Recommendations, Reference Committee No. 3

Since Resolution "A" is included entirely in Resolution "E", the Committee would like to recommend approval of Resolution "E" and that it be sent to the appropriate organization.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Resolution B—Council of KSMA

WHEREAS the practice of mail order merchandising of prescription drugs is now being carried on in our state; and

WHEREAS in this process the direct personal relationship which exists between the patient, physician and pharmacist at the community level is lost; and

WHEREAS the American Medical Association has gone on record as stating this practice is detrimental to the health and welfare of the people; therefore be it

RESOLVED, that this House of Delegates go on record as condemning this practice and that it instruct the Legislative Committee to study this problem and recommend to the Council any remedies that appear practical, and be it further

RESOLVED, that the KSMA express its appreciation to the Kentucky Pharmaceutical Association for taking a strong stand against this practice.

Recommendations, Reference Committee No. 3

Resolution "B"—Pertaining to Mail Order Drugs was approved.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Mr. Speaker, I move the adoption of the report as a whole. The motion was seconded and carried.

Reference Committee No. 3

Loman C. Trover, M.D., Madisonville, Chairman
Alfred O. Miller, M.D., Louisville
J. D. Handley, M.D., Hodgenville
Joe Bush, M.D., Mt. Sterling
Ruel T. Routt, M.D., Sonora

REFERENCE COMMITTEE NO. 4

Robert L. McClendon, M.D., Chairman

Reports on Miscellaneous Business

Report of the Committee to Study the Constitution and Bylaws

At the 1959 Session of this House of Delegates, tentative approval was given to a proposed amended constitution. Under the procedures set forth in the Constitution of KSMA for making changes in it, the proposal must be laid on the table for one year. In addition, all county societies must be notified at least two months in advance of the meeting of the House that changes in the Constitution will be voted on. This has been done.

It was explained to the House last year that there were two reasons the Committee had for suggesting the changes. The first was simply to clarify the wording in the Constitution. The second was to ask that the name of the Council be changed to the Board of Trustees. The advantages in changing the name of the interim governing body of the Association from Council to Board of Trustees are threefold. Many members and lay people do not understand what a Council is; they do understand what a Board of Trustees is, it would free the name "council" to be used in re-grouping the activities of the Association and finally, it would contribute to the efforts to streamline the committee structure.

This House approved in 1957 the recommendations of President Slucher, when he urged that the Association's committee structure be carefully studied by the Committee to Study the Constitution and Bylaws and that it be streamlined and made more effective. Because of conditions beyond its control the Committee was not ready to report in 1958. However, much progress was made during the year.

As the Committee moved ahead to make its recommendations to you in 1959, it was decided that the above recommended changes in the Constitution should be accomplished before the proposed changes in the Bylaws could legally be introduced.

The Bylaws Committee has held many meetings and spent uncounted hours in drawing up the report it is making to you now. The Association's legal counsel has been present at all meetings and has contributed effectively to the Committee's deliberations. If at the second meeting of the House Wednesday night, favorable action is taken on the constitutional changes, then the House will consider the report of the Bylaws committee. As you study the Bylaws proposed changes, you will note that while one of Doctor Slucher's recommendations, that the Bylaws be conformed, has been carried out, actually, the only major change in the intent of the Bylaws is the manner in which the committee work has been restructured. This has been done in chapter seven.

KSMA Committee to Study the Constitution and Bylaws

Robert S. Dyer, M.D., Louisville
Barton L. Ramsey, M.D., Somerset
Richard J. Rust, M.D., Newport
George H. Widener, Jr., M.D., Paducah
Cooley L. Combs, M.D., Chairman, Hazard

Recommendations, Reference Committee No. 4

This report deals with the activities of the Bylaws Committee and the proposed changes in the Bylaws of the KSMA. The proposed Bylaws were read and accepted with the following amendments and deletions:

1. The first sentence in Section 2, Chapter V amended to read as follows:

"The President-Elect shall assist the President in visitation of county and other meetings."

2. Add the following to Section 3, Chapter V: "In the event of a vacancy in the office of the President, the Vice President from the district from which the President was elected shall succeed to the office of the President."

3. The second sentence in Section 1, Chapter VI be amended to read as follows: "The Board of Trustees which consists of the duly elected trustees, the President, the President-Elect, the three Vice-Presidents, the immediate past president, the Speaker and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the AMA."

4. The third sentence of Section 2, Chapter VI—at the end of the sentence, the following statement to be inserted: "By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein."

5. Delete the last sentence of Section 4, Chapter XI, which reads: "When a county contains more than one medical society, friendly overtures and concessions shall be made, with the aid of the Trustee of the District, if necessary, and all of the members brought into one organization, if possible."

Mr. Speaker, I move the adoption and full implementation of this section of the report. The motion was seconded, and carried.

Report of the KSMA Committee to Study the Need for Benevolent Fund for Members

This committee was formed as a result of action of the 1959 meeting of the KSMA House of Delegates. The purpose of this committee was to explore the possibility of KSMA establishing a fund which would be of assistance in case of financial emergencies to our members, their widows or other dependents.

It is recognized that this is a worthy cause. Many state medical associations have established such funds. The Los Angeles County Medical Association is contemplating the building of a home for retired physicians who need financial assistance.

Our committee feels that in the absence of any apparent acute need at this time that this matter be carefully explored.

Our committee also recommends that this question should be referred to an existing committee such as the KSMA Committee on Education and Economics to survey the situation and after thorough study make a complete report to the House.

Finally, if the House of Delegates agrees with the above recommendations then we would recommend that this committee be disbanded.

Committee to Study the Need for Benevolent Fund for Members

Richard Slucher, M.D., Louisville
Edward Mersch, M.D., Covington
Robert W. Robertson, M.D., Paducah, Chairman

Recommendations, Reference Committee No. 4

This report states that this committee recognized this study to be a worthy one. It recommended this question be referred to an existing committee. Your reference committee accepts this report and recommends that this question be referred to the new Council on Medical Services for survey and disposition as it sees fit.

Mr. Speaker, I move the adoption and implementation of this section of the report. The motion was seconded and carried.

Report of the Advisory Committee to Selective Service

This committee does not have a report.

Advisory Committee to Selective Service

Sydney G. Dyer, M.D., LaCenter
J. Duffy Hancock, M.D., Louisville
Charles B. Billington, M.D., Paducah
O. B. Coomer, D.D.S., Louisville
F. E. Hull, D.V.M., Lexington
Frank W. Jordan, D.D.S., Louisville
Lula B. McClain, R.N., Louisville
Sam A. Overstreet, M.D., Louisville
Marcus Randall, D.D.S., Louisville
L. O. Toomey, M.D., Bowling Green
Russell E. Teague, M.D., Frankfort
Glenn U. Dorroh, M.D., Lexington
A. Clayton McCarty, M.D., Louisville, Chairman

(Secretary's Note: Until recently this committee has not had any matters referred to it and therefore has been relatively inactive. Since the illness of the chairman, A. Clayton McCarty, M.D., Louisville, who has been out of the state some time, J. Duffy Hancock, M.D., Louisville was asked to fill in during Dr. McCarty's absence).

Recommendations, Reference Committee No. 4

This committee did not have a full report due to the illness of the Chairman. The reference committee recommends that this committee continue its necessary work of being available for any problems that may arise. It is hoped a report will be submitted in the future.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Mr. Speaker, I move the adoption of this report as a whole. The motion was seconded and carried.

Reference Committee No. 4

Robert L. McClendon, M.D., Chairman
H. F. Chambers, M.D.
C. D. Snyder, M.D.
Dave H. Thurman, M.D.
John Sonne, M.D.

REFERENCE COMMITTEE NO. 5

O. Leon Higdon, M.D., Chairman

Miscellaneous Business

Report of the Medico-Legal Administrator

The Medico-Legal Administrator has been fairly active throughout this past year. We are still unusually fortunate in Kentucky that there has been no noticeable increase in the number of professional liability problems. The principal duty of the Medico-Legal Administrator has developed into a liaison between the doctors and attorneys involved in professional liability matters. Constant efforts on the part of the doctor to render a better service will assure us of a still lower professional liability rate.

Medico-Legal Administrator

J. D. Gordinier, M.D., Louisville

Recommendations, Reference Committee No. 5

Reference Committee No. 5 has studied Report No. 13 of the Medico-Legal Administrator. The content of this report is that of a very pleasing situation in that there has been no noticeable increase in the number of professional liability problems. Doubtless, many factors have contributed to this healthy situation, none the least of which has resulted from the untiring efforts of the Medico-Legal Administrator, J. D. Gordinier, M.D., who has continued his efforts in developing liaison between doctors and to others involved in professional liability matters. Certainly, constant efforts on the part of the doctor to render a better service will assure us of still fewer professional liability problems.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Report of the KSMA Liaison Committee to Voluntary Health Groups

This Committee has been active throughout the year. Through the help of the staff of KSMA and after numerous discussions with various members of the Committee, a letter has been formulated which was forwarded to the attached list of Voluntary Health Groups which operate in the state of Kentucky. We are pleased to inform you that as of this date we have had replies from eight of these organizations signifying their interest in our Committee and most of them expressing the idea that they thought the Committee was worthwhile and should lead to better understanding among such groups. They have also sent lists of their Medical Advisory Committees and physicians who aid them in setting up their Voluntary Health Programs.

At our meeting on May 5, 1960, the new name of the Committee was formally announced. In addition to this, the recommendations of the 1959 House of Delegates of the AMA were reviewed. Each Com-



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Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours[1,2] . . . or approximately one-half the time of other once-a-day sulfas.[2] Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.[2] Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.[3]

Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies[5] in 223 patients showed TOTAL side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annua 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1057 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.



once-a-day sulfa . . .

NOTE: Investigators note a tendency of some patients to misinterpret dosage instructions and take KYNEX on the familiar q.i.d. schedule. Since one KYNEX tablet is equivalent to eight to twelve tablets of other sulfas, even moderate overdosage may produce side effects. Thus, the single dose schedule must be stressed to the patient.

KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz. Recommended Dosage: Children under 80 lbs.: 1 teaspoonful (250 mg.) for each 20 lb. body weight, the first day, and ½ teaspoonful per 20 lb. per day thereafter. For children 80 lbs. and over: 4 teaspoonfuls (1.0 Gm.) initially and 2 teaspoonfuls daily thereafter. Give immediately after a meal.

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NEW—for acute G.U. infection AZO-KYNEX® Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.

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Lederle

mittee Member was provided with a copy of the Handbook for Medical Societies and individual physicians on National Voluntary Health Agencies.

It is the feeling of the Committee that there has been some real progress made in carrying out the purposes for which this Committee was originally organized.

KSMA Liaison Committee to Voluntary Health Groups

Marion F. Beard, M.D., Louisville
C. M. Bernhard, M.D., Louisville
McDaniel Ewing, M.D., Louisville
K. Armand Fischer, M.D., Louisville
L. M. Foltz, M.D., Louisville
T. M. Marshall, M.D., Louisville
L. H. Segerberg, M.D., Louisville
L. A. Taugher, M.D., Louisville
R. M. Denham, M.D., Louisville, Chairman

Voluntary Health Groups

Kentucky Association of Mental Health, Elizabethtown, Kentucky
Muscular Dystrophy Association of America, Louisville, Kentucky
United Cerebral Palsy of the Falls City, Inc., Louisville, Kentucky
Louisville Tuberculosis Association, Louisville, Kentucky
Kentucky Society for Crippled Children, Louisville, Kentucky
Louisville Heart Association, Louisville, Kentucky
Kentucky Heart Association, Louisville, Kentucky
National Foundation for Infantile Paralysis, Louisville, Kentucky
Jefferson County National Foundation for Infantile Paralysis, Louisville
Arthritis & Rheumatism Foundation of Kentucky, Louisville, Kentucky
American Cancer Society, Louisville, Kentucky
American Red Cross, Louisville, Kentucky
Kentucky Tuberculosis Association, Louisville, Kentucky
Rehabilitation Center, Inc., Louisville, Kentucky
Louisville Deaf & Oral School, Louisville, Kentucky

Recommendations, Reference Committee No. 5

Mr. Speaker, Reference Committee No. 5 has reviewed the report of the KSMA Liaison Committee to Voluntary Health Groups. As of May 5, 1960, the above new name of this committee was formally announced. It is to be noted that this committee has been very active throughout the year and had implemented the suggestion of the House of Delegates of 1959 in that contact was made with numerous voluntary health groups which operate in the state of Kentucky informing them of the wish and the intent of this committee to assist, in any way possible, in their program. This follows the recommendations of the 1959 House of Delegates of the American Medical Association. Throughout the state the component county medical society has urged its membership to participate at the local level in the activities of the numerous voluntary health groups. It is to be noted that replies have been received from 8 of these organizations, signifying their interest in our committee and most of them expressing the idea that they thought the committee was worthwhile and should lead to better understanding among such groups. It is the recommendation of Reference Committee No. 5 that the work of this Liaison Committee be continued and encouraged.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Report of the Committee on Rural Health

The Rural Health Committee sponsored, with the Rural Health Council, the seventh annual Kentucky Rural Health Conference at Bowling Green, November 5, 1959. This was a new idea in rural health conference. It was moved from populated centers where we were getting a fairly good crowd, but we were catering to the same people year after year, so it was a recommendation of your rural health committee that the rural health conference be moved out in the State where farm people could attend the meeting, after having done their morning chores, and return in the evening, in sufficient time to do their evening chores.

A program was planned with this in mind. The theme for this rural health conference was "Horizons in Rural Health," borrowed from the National Rural Health Conference. The program worked up by the program committee of the Rural Health Council of Kentucky was a good one, and was well received by those in attendance. Mr. Bill Rudd did yeoman service in contact and public relations work, in the area near Bowling Green. He tried to contact all the counties and the cooperating organizations in the surrounding area, that is to say in an approximately 60-mile radius of Bowling Green. The attendance was excellent, we had 154 registrations.

The Rural Health Committee met on two occasions, to plan the 1960 conference, and it was decided to hold the rural health conference this year at Morehead State College, at Morehead, Kentucky. The same procedure is to be followed in the vicinity of Morehead, as Mr. Rudd is to do extensive public relations work in that immediate vicinity. Adron Doran, president of Morehead College, and his associates have already given us fine cooperation and the health conference is to be held in the Adron Doran Student Union Building, October 27. The program is about completed and the theme of this year's meeting will be "Partners in Health."

The Rural Health Council has been very cooperative, and has helped to complete the program, and has been instrumental in obtaining several of the speakers. Governor Bert Combs will be the dinner speaker, preceded by a very fine array of morning speakers, and followed by as equally astute speakers in the afternoon. The committee plans to have in the hands of all high school principals and guidance faculty advisers, a work kit on "Partners in Health," to encourage medical and paramedical careers for our rural boys and girls.

The rural health committee feels that it is imperative that we encourage our Kentucky youth to take the fullest advantage of facilities at the University of Louisville Medical Center, which is in process of being built, also the University of Kentucky Medical Center, which is nearing completion. We believe that Kentucky has ample youth of ability, to take full advantage of these facilities, and help pull our State forward, to become a leader in the medical and paramedical fields. We definitely feel that this program will help to alleviate some of the shortages in our rural areas, in medicine and paramedical sciences. There is little advantage in the education of physicians, without ample nurses, pharmacists, and other allied personnel.

The rural health committee is very appreciative of the help rendered by Bill Rudd, Dr. Donald Graves, who served as the program chairman, Mrs. Alda Hennick, of Lexington, Kentucky Extension Department, Dr. L. J. Thomas, Manchester, Kentucky, Mr. James Patton, Frankfort, Kentucky, State Department of Vocational Education. Bill Rudd should be further commended for his excellent job of public relations at Bowling Green. His work there, I am sure, made the State Medical Association many friends, in that

vicinity. The State Headquarters office has been extremely cooperative and without their aid, the task would have been impossible.

Committee on Rural Health

Joseph R. Miller, M.D., Benton
Nathan Canter, M.D., Owensboro
Ralph D. Lynn, M.D., Elkton
Dixie E. Snider, M.D., Springfield
C. C. Howard, M.D., Glasgow
Wyatt Norvell, M.D., New Castle
Wilbur R. Houston, M.D., Erlanger
James S. Williams, M.D., Nicholasville
Donald L. Graves, M.D., Frenchburg
George P. Carter, M.D., Louisa
Carl Pigman, M.D., Whitesburg
Theodore R. Davies, M.D., Barbourville
Ansel V. Simon, M.D., Middletown
Frank L. Duncan, M.D., Monticello, V. Chairman
Mitchell B. Denham, M.D., Maysville, Chairman

Recommendations, Reference Committee No. 5

Reference Committee No. 5 wishes to report on the work of the Committee on Rural Health—Number 27. The Seventh Annual meeting of the Kentucky Rural Health Conference was held at Bowling Green, Kentucky on November 5, 1959, 154 persons attended and registered. The meeting was well received and is evidence of the good work done jointly by the KSMA Committee and the Farm Bureau. Mr. Bill Rudd of the KSMA office is to be complimented for his service in arranging this meeting and for the good public relations he was successful in promoting.

Two committee meetings have since been held to plan the 1960 conference which is to be presented at Morehead State College on next October 27th. A review of the program for that meeting will leave no doubt as to the serious efforts of this important committee of KSMA to cooperate with the rural citizens of Kentucky and to bring to them the knowledge and value of good medical care.

The reference committee recommends to the House of Delegates that the executive secretary of KSMA be instructed to inform Mr. John Koon, executive secretary of the Kentucky Farm Bureau, that we are most grateful to him for the very efficient manner in which he has cooperated with the KSMA Committee on Rural Health.

Mr. Speaker, I move the adoption and implementation of this section of the report. The motion was seconded and carried.

1960 RURAL HEALTH CONFERENCE PROGRAM
"PARTNERS IN HEALTH"

Morehead, Kentucky
October 27, 1960

Morning Session, John Koon, Executive Secretary, Ky. Farm Bureau, Presiding

9:00 Registration
9:25 Invocation—Mr. Henry Haggan, Head Agriculture Dept., Morehead State College
Announcements—D. L. Graves, M.D., Frenchburg
Greetings—Richard Elliott, M.D., President, Kentucky State Medical Association
9:45 Official Welcome—Mr. J. C. Zimmerman, Director, Industrial Development, Kentucky Chamber of Commerce
10:00 Panel Discussion—"Health in Relation to Economic Development—The Problem"
Mr. P. F. Ayer, Berea, Exec. Secy., Council of Southern Mountain Workers, Moderator
Alec Spencer, M.D., West Liberty
Mr. B. F. Reed, Drift, Chairman, Eastern Ky. Regional Planning Commission
Dr. Jim Brown, University of Ky. Rural Sociology Dept., Lexington
10:45 Milk Break—Served by Dairy Princess
11:00 Panel Discussion—"Health in Relation to Economic Development—Present and Available Resources"
Edwin H. West, M.D., Dir. of Local Health Service, State Health Department, Frankfort
Mr. Otto Ingram, Judge, Menifee County
Mr. Scott True, Maysville, Farm Director WFTM
Mr. Dave Aronberg, Mayor, Ashland
11:40 "What Can, What Have, and What Are We Going To Do"—Audience Participation
Luncheon Session—Mitchell B. Denham, M.D., Maysville, Chairman Rural Health Council, Presiding
Address by Governor Bert Combs—
Dinner Music by Mrs. Adron Doran
Afternoon Session, Miss Alda Henning, Lexington, UK Agric. Extension Serv., Presiding
1:45 Panel Discussion—"Careers in Health"
Moderator—Dr. Francis Hutchins, President Berea College
Panel
E. B. Gernert, DMD, State Health Department, Frankfort
C. C. Howard, M.D., Glasgow, Chairman, Rural Ky. Medical Scholarship Fund
Mr. Fred Martin, Director, Industrial and Distributive Education, Frankfort
Mr. Bob Johnson, Director of Community Services, University of Kentucky Medical Center, Lexington
3:15 Farewell Address—Dr. Adron Doran, President, Morehead State College

Report of Representative to Conference of Presidents and Other Officers of State Medical Associations

The Conference of Presidents and other Officers of State Medical Associations Meeting was held at the Americana Hotel in Miami Beach, Sunday afternoon, June 12. A number of Kentuckians were present including our delegates, alternates and Headquarters Staff representatives.

The program consisted of four excellent presentations in the field of socio-economics. Mr. Paul Butler and Mr. Thruston Morton discussed the current philosophies and approaches of their respective parties to the problem of health care for the aged.

Irvin Abell, Jr. M.D., Louisville
Representative

Recommendations, Reference Committee No. 5

Reference Committee No. 5 acknowledges with appreciation the effort of our president, Doctor Abell, in attendance at this conference which was held at Miami Beach June 12th.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded, and carried.

Report of KSMA Representative on Kentucky Health Council

Since the formation of the Committee to work with the Kentucky Health Council, there has been no action and any further development concerning the Health Council. The last known action was a meeting of the Nominating Committee choosing names of individuals to be placed before a called meeting of the member organization of the Health Council.

Since this time there has been no further action and therefore there is nothing in addition to report.

Carl Cooper, Jr., M.D.,
KSMA Representative on
Kentucky Health Council and
Chairman, Committee to work
with Kentucky Health Council

Recommendations, Reference Committee No. 5

Since the formation of the committee to work with the Kentucky Health Council, there has been no action and no further devclopment concerning the health council. The last known action was a meeting of the nominating committee choosing names of individuals to be placed before a called meeting of the member organization of the health council. Since this time there has been no further action, and therefore there is nothing additional to report.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Report of the KSMA Advisory Commission to Blue Shield

The KSMA Advisory Commission to Blue Shield has completed its second year of activity. Except for one change in its personnel, the membership of the Commission is the same as it was in the preceding year.

One meeting of the Commission was held on May 12, 1960, with a majority of the members present.

At the meeting of the KSMA House of Delegates on September 23, 1959, three recommendations of the Advisory Commission to Blue Shield were approved by the House of Delegates. The first of these was that an educational program be carried out to acquaint the members of the KSMA with the advantages and disadvantages of both the service and idemnity types of Blue Shield coverage, and that further consideration by the House of Delegates of the advisability of changing to a service type of plan be deferred until after completion of the educational program.

Through the medium of the Insurance Page of the Journal, and by means of open discussion of the factors involved in many of the county medical society meetings, most of the members of the State Association had an opportunity to avail themselves of the viewpoints of the proponents of both types of plan. Following the completion of the program of education, it became the opinion of the Council of the KSMA that there was not enough sentiment at this time among the members of the Association in favor of a service type of plan to warrant calling a special session of the House of Delegates to vote on the question.

The second recommendation of the Advisory Commission, which was approved by the House of Delegates, was that the proposed special indemnity program of Kentucky Physicians Mutual, Inc., which had been developed in behalf of the group over 65, of low income and limited resources, be approved and that physicians, whenever possible, accept the allowances offered by the plan to this limited group as payment in full.

During the month of November 1959, a two week enrollment period in this plan was held. There were nearly 1300 applications, and as of May 12, 1960, seven hundred sixty-one were enrolled under this program. In this connection, it may be pointed out that 70,000 people beyond 65 are already enrolled under Blue Shield in this state, which represents almost 30 per cent of those in this age group. Many of the others are receiving aid through Old Age Assistance programs, or are protected to some degree by prepayment coverage other than Blue Shield. There are also many aged whose resources are sufficient that they do not need any type of help in providing for their own health care.

The third recommendation of the Advisory Commission to Blue Shield, which was approved by the House of Delegates was that in filling in the physicians' claim form for any of the Blue Shield contracts, the physicians should list the charges actually rendered by them for the services rendered.

Response to this latter request of the House of Delegates has been excellent on the "preferred" contracts, but in filling the claim forms for the standard contracts about 20% of the physicians, for one reason or another, have failed to list their fees for the services. It would serve many useful purposes if all of these fees are listed, and the Medical Advisory Commission again strongly urges that all physicians cooperate in this matter.

At the last meeting of the Commission, it was pointed out by several of the members that some of the specialty groups in our state association, as well as the Kentucky Chapter of the Academy of General Practice, feel that the fees which are allowed by our Blue Shield plan for some of their services are not always equitable in comparison with those allowed for some other services. It was recommended by the KSMA Advisory Commission to Blue Shield that the Board of Directors of K.P.M. institute a study to re-evaluate the entire schedule of indemnities, especially on the standard contract, and that existing inequities, if any, be corrected as far as possible. This recommendation was considered by the Board of Directors of Kentucky Physicians Mutual, Inc., and a committee of this body has been instructed to carry out such a study, and to make the appropriate recommendations.

The members of the KSMA Advisory Commission to Blue Shield again wish to express their appreciation to Mr. Lane Tynes and his staff, as well as to Mr. J. P. Sanford and the staff of the KSMA Headquarters office, for the help and cooperation which all of these have given throughout the year. The Chairman of this Commission is deeply grateful to all of the members for their enthusiastic and unselfish participation in the work of this organization.

KSMA Advisory Commission to Blue Shield

Keith Smith, M.D., Corbin
Richard R. Slucher, M.D., Louisville
Malcom D. Thompson, M.D., Louisville
Harry S. Andrews, M.D., Louisville
Garnett J. Sweeney, M.D., Liberty
C. Walker Air, M.D., Ludlow
Alfred O. Miller, M.D., Louisville
William R. Willard, M.D., Lexington
J. Murray Kinsman, M.D., Louisville
Louis M. Foltz, M.D., Louisville
Robert A. Orr, M.D., Mayfield
Arthur H. Keeney, M.D., Louisville
Fred M. Williams, M.D., Louisville
James T. McClellan, M.D., Lexington
William K. Massie, M.D., Lexington
Donald B. Thurber, M.D., Louisville
Hugh Houston, M.D., Murray
Sam A. Overstreet, M.D., Louisville
Chester M. Blanton, M.D., Paducah
John C. Weeter, M.D., Louisville
W. Vinson Pierce, M.D., Covington, Chairman

Recommendations, Reference Committee No. 5

Report No. 22—KSMA Advisory Commission to Blue Shield

Mr. Speaker, Reference Committee No. 5 has reviewed Report No. 22 of the KSMA Advisory Commission to Blue Shield.

The Advisory Commission to Blue Shield held one meeting during the past year, at which time three recommendations which had been approved by the House of Delegates at its 1959 session were discussed.

In regard to the question of a study of the advisability of the adoption of a service type contract by Kentucky Physicians Mutual, it was pointed out that a program of education concerning the relative merits of indemnity and service types of Blue Shield coverage had been carried out in the insurance page

of the Journal. Since the council of the KSMA was of the opinion that there was not enough sentiment at this time among the members of the association in favor of a service type plan to warrant further consideration, the council felt it unnecessary to call a special session of the House of Delegates to consider this problem.

In regard to the second recommendation of the Advisory Commission which was concerning a special indemnity contract developed by Kentucky Physicians Mutual for coverage of people over 65 having low income and limited resources, it can now be reported that a special enrollment period in this plan was held in November of 1959. There were nearly 1300 applications and of these, 761 were enrolled under this program. In this connection it was pointed out that about 70,000 people beyond the age of 65 had already been enrolled under Blue Shield in this state.

Our reference committee again concurs in the recommendation that, whenever possible, physicians agree to accept as full payment the allowances made by the special indemnity plan for services rendered to people over 65 having low incomes and limited resources.

It is the opinion of the reference committee that this new type of coverage has been well received and that the progress of this program should be carefully studied with a view to improving the coverage, both to this low income group, and to those senior citizens whose incomes may be beyond the present limitations but who are not presently covered by Blue Shield.

In regard to the recommendation of the House of Delegates that physicians should, in filling out their Blue Shield claim forms, list the fees which they had charged for the services, it was noted that in some instances this request had not been complied with. It is again the recommendation of this reference committee that physicians list the charges made by them for the services rendered, in filling out their Blue Shield forms.

The Reference Committee is glad to note that on the recommendation of the Advisory Commission to Blue Shield, the schedule of indemnities in the standard Blue Shield contract is currently being re-studied by the Board of Directors of Blue Shield, and that a revised schedule of indemnities will soon be offered to the subscribers. It is hoped that this may help to correct any inequities which may have existed in the old schedule of benefits.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Report of the Board of Directors of Kentucky Physicians Mutual, Inc.

The Board of Directors of Kentucky Physicians Mutual, Inc., presents its annual report to the Kentucky State Medical Association. It analyzes the eleventh year of operation and reflects the service offered by the Plan to the people and the physicians in Kentucky.

The past year has seen many developments. The Advisory Commission to Blue Shield appointed by the Kentucky State Medical Association, as indicated in the 1959 report to you, advised offering coverage to persons over age sixty-five. This was done during a two-week period in November of 1959. There were 1,284 applications received and 775 members from these were accepted. These members were limited to low income and low resources and receive a special coverage as previously reported to all physicians.

The Commission also recommended that Kentucky Physicians Mutual revise its basic schedule and other schedules so that the relation between the indemnities on various procedures will be more equitable. The Blue Shield Medical Advisory Committee has held a series of meetings and each Specialty Group has been approached to prepare schedules showing the relationship of procedures in their own special category. This revision should be completed within the next few months. However, in order to hold the line on the rates for our basic contract, there can be no appreciable increase in overall allowances on the basic indemnity schedule. Some may be increased and others reduced to bring them into line. Various other benefits in addition to the basic will now be offered. Some provide diagnostic and larger allowances for procedures at higher premium rates. As rapidly as possible the enrollment staff is trying to institute these in the various participating groups.

An important development during the year was the merger of Kentucky Physicians Mutual, Inc. and Medical Service Mutual of Ashland, Kentucky. Medical Service Mutual was a Blue Shield Plan covering eight counties in eastern Kentucky. This merger was effected April 1, 1960, and I am pleased to advise that your Blue Shield Plan now operates state-wide. Benefits and rates for the eastern Kentucky area were allowed to remain the same.

During the past year we have enrolled 86,977 persons, making a total Blue Shield membership on August 31, 1960 of 684,795 members. Because of adjustments at the first part of 1959 eliminating minor procedures, the Plan is operating at about a break-even point. During the first six months physicians received $2,896,711.00 from the Plan. Total payments for the year of 1960 will run almost $6,000,000.00 paid to Kentucky physicians.

The Board of Directors pledges itself to continued efforts in solving the problem of financing medical care for the people of Kentucky.

J. Vernon Pace, M.D.
President

Recommendations, Reference Committee No. 5

Reference Committee No. 5 has carefully studied the annual report of the Board of Directors of Kentucky Physicians Mutual, Inc., to the KSMA and is glad to note the continuing progress of our Blue Shield plan. The development of a new plan for offering coverage to persons over age 65 has already been mentioned in the report of the Advisory Commission to Blue Shield—Report No. 22—as has the study which is currently being carried out preparatory to revising the schedule of benefits in the standard contract. It was noted that in carrying out this study, several meetings have been held and each specialty group has been given the opportunity of preparing schedules showing the relationship of procedures in their own special category. The reference committee hopes that this close liaison with all of the groups concerned may result in increased support of our Blue Shield plan by the profession as a whole.

An important development during the year was the merger of the Medical Service Mutual of Ashland, Kentucky, with Kentucky Physicians Mutual. This means that our Blue Shield plan now operates statewide. During the past year almost 87,000 new subscribers were enrolled, making a total membership of nearly 685,000 members. The rapid growth of the plan is shown by the fact that during the year of 1960 almost six million dollars will have been paid out to Kentucky physicians by the plan.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Mr. Speaker, I move the adoption of this report as a whole. The motion was seconded and carried.

Reference Committee No. 5

Leon Higdon, M.D., Paducah, Chairman
E. C. Strode, M.D., Lexington
R. L. Shuffett, M.D., Greensburg
D. M. Greeley, M.D., Harlan
Austin Bloch, M.D., Louisville

REFERENCE COMMITTEE NO. 6

Carl Cooper, M.D., Chairman

Reports of Miscellaneous Business

Report of the Advisory Committee to the Editor

During the past year this committee held one meeting, at which time a number of matters pertinent to the publication of the Journal were discussed at length.

The resignation of Wallace E. Herrell, M.D., Lexington, as the special Symposium Editor of the Journal was received with regret and Edmund D. Pellegrino, M.D., Professor and Chairman of the Department of Medicine, University of Kentucky Medical Center, was elected to take his place. It was agreed that the October issue would be the 1960 Symposium number.

New appointees to the Board of Consultants were discussed and approved, a policy set on what to charge Voluntary Health Agencies for advertising, and it was decided to have a tax page every third month.

Much discussion was given to the policy of inserting the picture, in the Annual Meeting number of the Journal, of the incoming president as a loose sheet. After much discussion, it was decided to discontinue this practice with the 1961 issue, as it would save expense both in printing and the extra postage that the Post Office Department charges for it, and because it is a duplication since the same picture is carried as a part of the annual meeting number the year the president is in office.

The committee was acquainted with the third Regional Medical Editors' Conference that the Journal of KSMA is playing host to, next month in Lexington. This Conference meets every second year and the Texas Medical Journal was host at the 1958 session.

Our committee wishes to again express appreciation to our editor, Sam A. Overstreet, M.D., and associate editor, George W. Pedigo, M.D., for their dedicated efforts in giving us a Journal of constantly improving worth.

Advisory Committee to the Editor

Francis Massie, M.D., Lexington
Robert J. Hoffman, M.D., Ft. Mitchell
James Hix, M.D., Owensboro, Chairman

Recommendations, Reference Committee No. 6

This is the report of the Advisory Committee to the Editor to the 1960 session of the House of Delegates.

We wish to commend this Committee for the election of Doctor Edmund D. Pellegrino, Professor and Chairman of the Department of Medicine, University of Kentucky Medical Center, as special Symposium Editor of the Journal and express our thanks to Wallace E. Herrell, M.D., Lexington, for his service in this position prior to resignation.

Other action of this Committee was

(1) New appointees to the Board of Consultants
(2) Charges to the Voluntary Health Agencies for Advertising
(3) A Tax Page in the Journal every third month
(4) Deletion of insert of picture of the incoming president in the Annual Meeting issue of the Journal
(5) The Journal of the Kentucky State Medical Association as host to the Third Regional Medical Editors' Conference in Lexington.

Our Committee recommends that the Advisory Committee to the Editors have printed in the Kentucky State Medical Association Journal an explanation of the reason for necessity of charges to the voluntary health agencies for advertising.

Mr. Speaker, I move the adoption and implementation of this section of the report. Motion was seconded and carried.

Following discussion, a motion was made, seconded, and carried that the House of Delegates go on record as expressing appreciation to Wallace E. Herrell, M.D., Lexington, for his excellent work on the 1959 symposium issue of the Journal of KSMA.

Report of the Committee on Emergency Medical Service

The Committee on Emergency Medical Service has held one meeting during this association year on February 25, 1960. The members of the Jefferson County Civil Defense Committee also met with us in this meeting.

Present at this meeting was Mr. Forrest Stokes, U.S. Public Health Adviser, who had been assigned to the state of Kentucky to implement the role of civil defense and health mobilization in Kentucky. Since this meeting in February, Mr. Stokes has recruited nine physicians and one dentist, who have completed a week's training course in medical aspects of health mobilization at the Office of Civil Defense Center in New York.

These physicians who have completed this course will be designated as Health Service Cadre Officers to coordinate medical services for a local area in a national, statewide or local disaster. Kentucky is the first state to select and train its full quota of medical officers for health mobilization. These cadre officers are responsible to Russell E. Teague, M.D., Commissioner of Health, in the handling of emergency medical services for Kentucky Civil Defense.

As Chairman, I attended the 10th meeting of the Civil Defense Committee of the AMA at Chicago in November of 1959. This meeting emphasized that the points of communications, chain of command and the role of government in civil defense were some areas that needed to be surveyed closely.

Additionally, in April of 1960, I attended a conference of the Committee on Disaster Medical Care of the AMA Council, in Washington, D. C. This was a seven state regional meeting which is part of the AMA program in helping the states to achieve greater participation in medical civil defense affairs and to coordinate their activities with the state civil defense organizations.

Your President and one of the staff members of the KSMA Headquarters Office also attended a regional meeting in Washington, D. C., on February 15, 1960, which was primarily devoted to explaining the role the United States Public Health Service will play in the new role of civil defense under Public Law #875.

This is part of the role that Mr. Stokes is undertaking in Kentucky. This new program has five (5) main basic objectives: (1) Fix responsibility as to health services—manpower distribution—supplies; all in case of disaster, (2) decrease disparity between need and supply, (3) research and development, (4) holding training courses for cadre personnel and (5) to keep the public informed of anticipated problems in case of attack.

The efforts at organizing disaster plans have been vigorous and persistent for approximately 10 years. Much thoughtful and time consuming planning has gone into these efforts. However, even since the plan has become law by executive order (the President of the U.S.A.), there has been no real specific enthusiasm on the part of the rank and file physicians.

Without voicing an opinion otherwise, it is felt that some more specific tangible reward must be forthcoming for busy doctors than simply filling offices. It is felt that credit for medical reserve officers in all branches of service would greatly stimulate this program and would be materially beneficial for the disaster work and the reserve program. Physicians con-

tacted in the present program seem to fall into two categories; those who have worked for years with this problem and those who have done little or nothing and who are openly skeptical of a civilian program ever being effective.

It is felt that the best chance for any degree of success would be in a committee continuity so that the background and the thinking of its members could be effectively carried on—possibly a committee membership for 2-3 years and overlapping tenures.

With the USPHS serving as the health arm of the Office of Civil Defense, this committee hopes that it will not be too long until a program listing this chain of command can be instigated that will make it clear to all groups what their role can be in a sound and coordinated effort in case of attack or natural disasters.

Committee on Emergency Medical Service

Dexter Meyer, Jr., M.D., Covington
Coleman Johnston, M.D., Lexington
Winfrey P. Blackburn, M.D., Frankfort
Charles C. Kissinger, M.D., Henderson
W. B. Atkinson, M.D., Campbellsville
Morgan R. Colbert, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 6

We wish to commend the Committee for their study and suggestions for improvement of Emergency Medical Services. We wish to urge each member of the Association to read this report.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Report of the Advisory Committee to the Woman's Auxiliary

Our committee was not approached this year for consultation. Since there were no problems presented to it, it was not necessary for the committee to meet, hence we have no report to make.

Advisory Committee to the Woman's Auxiliary of the Kentucky State Medical Association

Joe Bush, M.D., Mt. Sterling
L. O. Toomey, M.D., Bowling Green
Clyde C. Sparks, M.D., Ashland, Chairman

Recommendations, Reference Committee No. 6

We are happy that no problems arose which demanded consultation from this Advisory Committee.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the Committee on Medical Services

The Committee on Medical Services consists of fourteen associate committees. Nine of these had no meeting during the year. Some members attended national meetings related to their committee specialty. However, no problem in our state necessitated a Committee Meeting. The five associate committees who had meetings are reported individually.

1. AGING. Earl P. Oliver, M.D., Chairman of the Committee. On 5-19-60 a meeting was held at the Brown Hotel. It was announced that the Medical Care Program for Indigent Persons was passed by 1960 General Assembly. It became effective 7-1-60 and funds will be available 1-1-61.

It was also announced that Blue Shield-Blue Cross opened coverage for persons 65+ years of age for 2 weeks and 1,280 people signed up for the plan, of which 775 were eligible.

Forand-type legislation was discussed at length. The committee noted with appreciation the stand taken by Congressman John C. Watts, 6th Kentucky Congressional District, in his role against the government controlled medical aid plan for the aged.

The opinion of all present was that all legislation shoud be postponed until after the White House Conference on Aging in January, 1961.

One or more members of the committee and a member of the KSMA office staff attended a meeting in Washington, D. C., June 12-13, 1959, also AMA Regional Conference on Aging in Cleveland October 28-29, 1959 and, third, a planning meeting April 22-23, 1960, in Chicago.

The Citizens' Commission on Aging was formed in Kentucky in 1958 as an outgrowth of National Legislation, which called for a White House Conference on Aging. The duties are: (1) To collect and gather data on the needs and resources concerning the aged; (2) to hold a state conference on aging; (3) to make a report to Washington on data collected, plus recommendations: It was taken by common consent that a letter should be sent to the Governor's Commission, explaining to the chairman that the Kentucky State Medical Association does have a committee on aging and that we are very much interested in this field and that we would offer our assistance and cooperation to the commission in any way possible.

There will be 32 delegates from Kentucky going to the White House Conference on Aging and seven will be physicians. Governor Combs has been very cooperative.

The Committee recommended to the Council that, if the expenses of Kentucky delegates were not paid by federally allocated funds, the KSMA pay our members' expenses.

It seemed to be the general feeling of the committee that the medical profession should emphasize a positive program for the aged and to point out that the individual has a personal stake and responsibility in taking care of himself. Along with the thinking that the medical profession needs to maintain its status quo and that it should use its resources in the individual doctors talking to their patients each day. By getting this down to a matter of dollars and cents, we should be more able to get the citizens to see what their stake is in medical care in the future.

2. CRIPPLED CHILDREN. K. Armand Fischer, M.D., Chairman, says that no formal committee meeting has been held. However, he has written to each member of the committee asking if they had any matter to be discussed and all said "no."

A statistical report by Marjorie K. Smith, M.D., concerning the activities of the Kentucky Crippled Children's Commission was enclosed.

The Commission has been handicapped during the last year by reason of lack of funds. However, the 1960 Legislature voted funds to increase the allotment for several years.

3. TUBERCULOSIS. R. E. Mardis, M.D., Chairman. The Committee met 7-16-60 and heard a report by Dorothy Magallon, M.D., Director of Tuberculosis Control, Kentucky State Health Department. She described educational and promotional plans, explaining how the health department and private physicians work together for the good of the patient.

The Associate Committee recommends that the KSMA endorse the following specific recommendations for tuberculosis control in the state:

(1) Request that all patients admitted to private hospitals in this state be screened carefully to detect tuberculosis. This to be done either by 14 x 17 chest films, 70 mm. photofluorograms or in the case of children under 15 years of age by tuberculin testing with x-ray follow-up of the positive reactors.

(2) Advise hospital radiologists to send reports both to the referring physician and to the local health department on all suspicious cases so

that they may be adequately followed and all of their contacts surveyed. The Health Department would assume final responsibility that such a follow-up be accomplished.

(3) Recommend that the Health Department supply all private physicians with PPD skin testing material free of charge. Advise all private physicians to give intradermal tuberculin test to all patients whose tuberculosis status is unknown and supply them with a card indicating the results of this test. Negative reactors to be retested yearly, positive reactors to be x-rayed yearly. It is to be optional with the private physician whether this is done in his own office, by a private consultant, in the local hospital, or by the Health Department. Duplication of effort to be avoided by patient education, simple but adequate records including a wallet card type of report which could be retained by the patient.

(4) Make readily available to all private physicians sputum mailing containers to facilitate sputum studies in all tuberculosis suspects.

(5) Recommend that representatives of the Health Department or other interested groups contact every physician in practice to obtain his cooperation with this program by explaining various aspects of it. This could be done by addressing county medical societies or other groups on request.

(6) Endorse the use of the mobile TB Detection and Consultation Unit in areas inadequately served by private physicians or established Health Department services at the present time. Continue systematic mass surveying procedures.

(7) *Emphasize the theme of tuberculosis control by adequate detection followed by adequate treatment.* Endorse the plan of making available without cost to the patient anti-tuberculous drugs, particularly isoniazid and PAS, for the long term therapy of tuberculosis.

The Chairman of the Committee on Medical Services does not agree with the seventh recommendation.

4. GENERAL PRACTICE. Homer B. Martin, M.D., Chairman. The Associate Committee on General Practice recommends that the KSMA, through its delegates to the AMA currently formulating a two-year program of postgraduate education for general practitioners, recommend this flexible program, including adequate surgery, obstetrics and gynecology. In this way, we shall fulfill our obligation to provide quality general practitioners who will be abe to meet *properly* the demands of the individual community.

Further, the members of the Committee feel that next year's Committee should make a study of the practicability of establishing Sections of General Practice in our two Medical Schools and explore methods of orienting students into this field.

5. MATERNAL MORTALITY. Robert F. Monroe, M.D., Chairman. The subcommittee on Maternal Mortality of the KSMA had three meetings to analyze the reported maternal deaths for the year 1959. The number of deaths to date have been less than for the same period in 1958; however the move to Frankfort slowed the function of the committee.

Suggestions for improvement:

(1) Most of the attending physicians are cooperating with the study by returning the questionnaires. Still the amount of factual information in most cases could be more detailed and this would aid the study. It was suggested a committee member personally go visit the attending physician on each death to enhance the information.

(2) The study has demonstrated the importance of a complete autopsy and the committee feels if this isn't obtained, for all the hospital deaths that aren't positively determinable clinically, the patient and the family have not received the best medical care to which they are entitled.

(3) The committee also feels that an open meeting held during the State meeting would help the practicing physicians to better understand just how the cases are anonymously studied and just how much depends on the data supplied. This might be done by presenting two cases—one a poor, inadequate return—the other an interesting, complete report.

(4) The committee further urges the legislative committee of the State to press for the 'privileged communication' that this committee rightfully needs to function optimally and actually all physicians should have—just as husband and wife, attorney and client, clergy and parishioner.

Committee on Medical Services

Marion F. Beard, M.D., Louisville
James C. Drye, M.D., Louisville
Otto H. Salsbery, M.D., Covington
K. Armand Fischer, M.D., Louisville
Franklin B. Moosnick, M.D., Lexington
Albert S. Warren, M.D., Lexington
Homer B. Martin, M.D., Louisville
Earl P. Oliver, M.D., Scottsville
George B. Sanders, M.D., Louisville
Robert F. Monroe, M.D., Louisville
Hollis Johnson, M.D., Louisville
Guy C. Cunningham, M.D., Ashland
Kenton D. Leatherman, M.D., Louisville
Richard E. Mardis, M.D., Louisville
David M. Cox, M.D., Louisville, Chairman

(Editors Note: The report of the Associate Committee on Diabetes was not received in time to be considered by the House of Delegates during the September 20-22, 1960 Annual Meeting. However, this report is being included at this point for your information.)

Recommendations, Reference Committee No. 6

The report of Committee on Medical Services to the 1960 session of the House of Delegates. This report consisted of reports on five (5) related Committees:

Aging
Crippled Children
Tuberculosis
General Practice
Maternal Mortality

We wish to commend the Committee for its study and interest in these agencies and move the adoption of the sections of this report concerning Aging, Crippled Children, General Practice and Maternal Mortality. We cannot move the adoption of the section of the report on Tuberculosis and we recommend that the Committee give further study to the basic problems involved.

Mr. Speaker, I move the adoption and implementation of this section of the report. The motion was seconded and carried.

Report from Associate Committee on Diabetes

The Associate Committee on Diabetes held its meeting on 7 June 1960. The results of the 1959 Diabetes Detection Drive were reviewed. In this Drive a total of 60,445 free tests were reported. These were divided into two groups, the first of which consisted of 39,930 tested by the KSMA program. In this group 606 positive urine sugar reactions were obtained which on follow-up yielded 276 new diabetics. The second group consisting of 20,515 were done through the State Department of Health, through the County Health Departments, through a program

initiated from the State Board of Health itself. This yielded 207 positive sugar reactions but further follow-up data as to the number of new diabetics discovered in this survey is not available.

Since the beginning of the drive in 1952, a total of 385,518 free tests have been carried out with a total of more than 1,386 new diabetics reported. This program has increased steadily in its scope from the initial 24,576 tests carried out in 1952 to its peak year in 1958 when 90,598 tests were carried out. This peak was reached in 1958 for two reasons, one being the inclusion of several surveys of public schools in the overall figures, and secondly the unusually good response from the individual counties.

In reviewing the results of the 1959 Diabetes Drive more specifically, it becomes apparent that any failure of the program resolves itself to failure at a local county level. In 1959 there were 32 counties which never appointed a county chairman. Of those counties who had chairmen there were 29 counties which failed to return any type of report. Further analysis of the results indicated that 10 counties reported a total of 30,896 tests made of the total of 39,930, approximately 75%.

The preparations and overall planning for the 1960 Drive were carefully renewed and previous materials were modified to bring out and emphasize the fact that this is one Drive which is not a fund raising drive but one in which the Medical Profession is attempting to render a service to the public, while providing general education in this disease. Details and techniques for obtaining a more prompt and adequate reporting system were discussed and these will be employed insofar as is feasible.

So far as specific suggestions for the function of this committee which might be propounded, would include the following: that this committee continue through the November Diabetes Detection Drive each year before it is replaced with a new committee, somewhere after the reporting and tabulation of the Drive has been completed; that the chairman of this committee serve at least two years and if possible that he be a member of the American Diabetes Association; that techniques be explored to secure greater participation at a county level in this Drive; and that perhaps the Auxiliary might be encouraged to participate actively at a county level in this service program.

The Kentucky State Board of Health was represented by Doctor Cameron of the Division of Chronic Disease Control together with other members of his staff and it is anticipated that a close relationship and participation between the State Board of Health and the individual county societies will be achieved. It was anticipated that the State Board of Health might operate The Clinitron at the Kentucky State Fair, while publicizing the need for a Diabetic Detection Program. However, problems arising from moving the Department to Frankfort, plus personnel shortages forced a last minute cancellation of this activity.

In closing we would like to emphasize once again the value of this program as a positive technique of good public relations between the physicians of the state and the general public. This is one of the few health drives which is carried out exclusively by the Medical Profession, and is one in which a service is rendered without any requests for funds, support or participation on the part of the public being asked.

KSMA Associate Committee on Diabetes

Franklin B. Moosnick, M.D., Lexington, Chairman
George P. Carter, M.D., Louisa
Marcus A. Coyle, M.D., Springfield
Thomas J. Crume, M.D., Owensboro
Robert Hoffmann, M.D., South Fort Mitchell
Arthur T. Hurst, M.D., Louisville
Esten S. Kimbel, M.D., Frankfort
George McClain, M.D., Benton

Report of the KSMA Adviser to University of Louisville Student AMA Chapter

During the past year the University of Louisville Chapter has been contacted numerous times concerning their problems that would be pertinent to our nature. They have also, on occasion, called us for advice and information. One item in particular was the allocation of funds to assist their trip to the Student AMA Meeting held in Los Angeles in May.

Attempts also were made to allow for a meeting with the Chapter during the regular meetings, but because of the school curriculum no definite program could be established as yet. It is generally felt that this will be advantageous and will aid us in our help to them as well as being a way that we can best know their problems. This has been proposed to the president, and it is felt in the coming year that a definite council meeting will be held and that the adviser will be notified in advance so that the meetings can be attended.

The University of Kentucky School of Medicine is starting its first class in September of this year. It is felt that an adviser to this Chapter, or an adviser to serve both Chapters, would be in order and this recommendation is proposed.

The delegates to the Student AMA Meeting in Los Angeles submitted a full report to us on their return. It is available in the KSMA office for those who wish to read it. It is most commendable. The scope and vision which these young men have advanced and concerned themselves so deeply with the problems of organized medicine is most refreshing.

Hoyt D. Gardner, M.D., Louisville
KSMA Adviser to University
of Louisville Student AMA Chapter

Recommendations, Reference Committee No. 6

Report No. 33 KSMA Adviser to University of Louisville Student AMA Chapter

We commend Hoyt D. Gardner, M.D., for his work as Adviser to the University of Louisville Student AMA Chapter and recommend the appointment of a similar Adviser to the University of Kentucky School of Medicine.

Mr. Speaker, I move the adoption and implementation of this section of the report. The motion was seconded and carried.

Report of the Woman's Auxiliary to the Kentucky State Medical Association

The Woman's Auxiliary to the Kentucky State Medical Association has completed its thirty-seventh year, and as president I am pleased to present a summation of the year's accomplishments.

The Delegates from the Woman's Auxiliary to the Kentucky State Medical Association to the annual Convention, held in Miami Beach, were: Mrs. Earl W. Roles, Louisville, president-elect; Mrs. Carlisle Morse, Louisville; Mrs. George Archer, Prestonsburg; Mrs. Guy Morford, Owensboro; Mrs. Charles B. Johnson, Russell, presidential delegate; Mrs. Vernon Pace, Paducah, alternate.

THE 29TH AUXILIARY—There has been a new Auxiliary formed in Montgomery County which brings the component Auxiliaries to 29. Counties now organized, 43. Members-at-large, 137. Total Auxiliary Membership, 1295.

AMERICAN MEDICAL EDUCATION FOUNDATION—Beginning with the inaugural address and continuing throughout the year this project was in-

tensely emphasized and promoted through the Distaff of Medicine with the result that $1524.00 was contributed.

BULLETIN—This is the official publication of the Auxiliary to the American Medical Association. Five Kentucky Auxiliaries; Calloway, Clark, Johnson-Floyd-Magoffin, Pike, and Warren—were on the National Honor Roll with one hundred per cent Bulletin subscriptions in each Auxiliary. Total State subscriptions 153.

CANCER SPEECH CONTEST—The Tenth Annual Public Speaking Contest on Cancer sponsored by the Auxiliary to the Kentucky State Medical Association and The Kentucky Division of the American Cancer Society and Extended Programs, University of Kentucky, was held at the Fine Arts Building on the University of Kentucky campus in April. The first prize of $100.00 was awarded Cecelia Ann Craft of Cumberland.

HUMANITARIAN FACETS—All 29 Auxiliaries have participated in society's "large hearted" programs namely: *Tuberculosis, Diabetes, Heart, Cancer.* The Membership gives much time to *Hospital Auxiliaries* and their accompanying gift shops through the State. Work in *Civil Defense* was done at the County level cooperating with local Civil Defense projects. *Rehabilitation* work was done with retarded children, spastic children, and tuberculosis patients.

The *Mental Health* aspect of the State's Program has been accentuated with the result: 20 Counties had Mental Health Chairmen; 10 Counties had Mental Health Programs. Some ways this Program materialized: dissemination of literature; a Mental Health Group organized; a clothing campaign for patients who were to be dismissed from institutions; help in promotion of a Mental Health Center; money given for Retarded Children's Programs; Christmas gifts for one Institution; help in Mental Health Clinic.

Advocated in the *Safety* area were Driver Training Courses in High School, Driver Agreements, and careful storage of Poisonous Articles. Farm and Home Safety was stressed through the Rural Health Program. An "Action Program" for Traffic Safety was executed by one Group. Spot announcements on Radio were used to emphasize Safety.

BLUE GRASS NEWS—This is the State Auxiliary's Publication issued quarterly to all Members, National Officers, and Presidents of surrounding States. It carries the Organization's news; articles by Officers and Members; relates the progress of the component Auxiliaries.

MECHANISM OF THE AUXILIARY—The Officers, Councilors, Coordinator, County Auxiliary Presidents, Past Presidents' Chairman, Nomination Committee Chairman and her Committee, Representative to Southern Auxiliary, cooperated and contributed most admirably; the BYLAWS Chairman and PARLIAMENTARIAN watched our parliamentary manners.

UNIQUE CLASSIFICATION—Benevolence is a fund created for the purpose of helping Kentucky physicians or their families. Each year the amount increases.

Doctor's Shop, McDowell House, Senior's Day Tea, given for the wives of senior medical students, and the observance of Doctor's Day are special Committees of the Auxiliary functioning for special projects.

RURAL HEALTH—The Rural Health Committee allies itself with the Kentucky Rural Health Council and other Farm Agencies. The purpose is to increase Medical Education and understanding among Kentucky farmers and its profession.

PARAMEDICAL CAREERS RECRUITMENT—Many avenues of approach have been used to interest prospective candidates in the Paramedical fields; speakers, skits, dramatic sketches, lectures by local health authorities, conducted tours, field trips, teas, films. Total Auxiliary scholarships awarded—12. Paramedical Careers Clubs organized by Auxiliaries—60. The members of these Clubs frequently do volunteer work in their local hospitals.

LEGISLATION—The Auxiliary did a colossal job in Legislative work on the State and National level. Legislative Chairman and County Presidents were contacted many times; quantities of literature mailed. Result—innumerable number of letters and resolutions mailed to Kentucky and National Legislators on pertinent Medical Legislation.

PROGRAM—This department of the Auxiliary has stressed the aims given by the National Auxiliary but emphasized the necessity of scaling the work and program to the particular locality. There has been diversity in the presentation of these various programs.

PRESIDENT'S REPORT—As president-elect and president, I attended the Auxiliary to the American Medical Association Meetings in Atlantic City and Miami Beach; the Auxiliary to the Southern Medical Association in New Orleans and Atlanta; two fall Conferences in Chicago; County Society Officers' Conference in Lexington; Rural Health Council and Rural Health Conference in Bowling Green; KSMA Rural Health Committee Meeting and Rural Health Council in Lexington; presided at four Board Meetings—three in Louisville and one in Lexington; attended the Chesapeake and Ohio Surgeons' Meetings in White Sulphur; KSMA Legislative Committee Meeting in Louisville; Doctor's Day celebration in Louisville; accompanied the Kentucky Delegation on a Good Will trip to Washington; attended the Cancer Speech Contest in Lexington; Kentucky Heart Association in Louisville; Kentucky Academy of General Practice ladies' activities, in Louisville; Ninth Ohio District Meeting in Portsmouth; workshop in Ironton, Ohio; Boyd, Carter, Greenup District Meeting; Doctor's Day in Ashland; Senior Tea for Senior Medical Students' Wives in Louisville; Auxiliary Meetings in Pikeville, Lexington, Bowling Green, Owensboro, Madisonville; Tennessee State Convention in Nashville; Ohio State Convention in Cleveland; West Virginia State Convention in White Sulphur.

Representing Kentucky in the Woman's Auxiliary to the Southern Medical Association will be Mrs. Charles B. Johnson, Russell, beginning this appointment post-convention in November.

The president wrote an article for each issue of the Blue Grass News; two articles for the National Bulletin; compiled a History of the Auxiliary's activities for the year; completed State's report for the National Auxiliary.

There has been a prodigious amount of materials, literature, instructions, articles, and correspondence emanating from the President's office.

This report is made possible by the cumulative efforts of the combined Auxiliary. To all who have made it possible I am so very grateful and say, thank you with all my heart.

Woman's Auxiliary to the Kentucky State Medical Association
Mrs. Charles B. Johnson, President

Recommendations, Reference Committee No. 6

It is encouraging to this Committee to note the tremendous efforts and results of the Auxiliary in the activities related to organized medicine. We are proud of our Auxiliary and thank them. The President of the Auxiliary, Mrs. Charles B. Johnson of Russell, deserves special recognition for her untiring efforts and extensive travel in carrying out the duties of her office.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Report of the Representative on the Kentucky Public Health Association Legislative Committee

The function of the Kentucky Public Health Association Legislative Committee is primarily that of the member groups submitting proposed state legislation to this committee for its study and from this committee on to the Board of Directors of the KPHA for their consideration and approval. The thinking in formulating this committee is that theoretically this would tend to give proposed legislation more impetus if backed by the KPHA.

This committee has met twice during the association year and invitations for membership were sent to the Kentucky Society of Crippled Children, State Department of Health, Kentucky Tuberculosis Association, National Foundation, Kentucky Heart Association, Cancer Association, Kentucky Department of Education, and the Kentucky State Medical Association.

Those present at the first meeting felt that it would be impossible for the members of this committee to do more than to give their own personal opinion on proposed legislation brought before this committee. For instance, I cannot speak for KSMA unless the proposed legislation has been studied by the KSMA governing body and officially sanctioned.

The first meeting closed with a request that all groups submit their proposed legislation to the committee for its study at a later meeting. Nothing of much importance transpired at this 2nd meeting and the KSMA never actually submitted its proposed legislation inasmuch as it had not yet been formally drafted.

J. Duffy Hancock, M.D.
Representative

Recommendations, Reference Committee No. 6

The report of the Kentucky Public Health Association Liaison Representative to the 1960 session of the House of Delegates is acknowledged for information.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Mr. Speaker, I move the adoption of this report as a whole. The motion was seconded and carried.

Reference Committee No. 6

Carl Cooper, M.D., Bedford, Chairman
Nathan I. Handelman, M.D., Louisville
M. C. Loy, M.D., Columbia
Robert Houston, M.D., Eminence
Howard I. Frisbie, M.D., Stanford

REFERENCE COMMITTEE NO. 7

Benjamin Boone, M.D., Chairman
Reports of Miscellaneous Business

Report of the Committee on Physicians Placement Service

This Committee met on May 26, 1960, at Lexington, to review and approve the activities of the Physicians Placement Service. The purpose of the Service was defined for benefit of the new members of the Committee and the activities were reviewed.

Since the last report of this Committee, the Service has broadened its scope. Senior medical students, interns and residents are encouraged to register and give their intentions as to type and location of practice. Contact is kept until the individual has located himself in practice.

Specialists have been added to our listings and benefits of the Service have increased manyfold.

Mr. Grogan and his staff are responsible for the progress of the Service.

At the last meeting of the Directors of the Rural Medical Scholarship Fund, the Chairman of the Placement Service Committee was elected a member of the Board of Directors of the Fund. A reciprocal arrangement, perhaps, should be made and the Chairman of the Fund should become a member of the Placement Service Committee.

All members of this Committee are interested in this service and think of it as one of the best functions of the Association.

Committee on Physicians Placement Service

Paul E. Holbrook, M.D., Ashland
Si A. Past, M.D., Olive Hill
James C. Salato, M.D., Columbia
Walter S. Coe, M.D., Louisville
Russell E. Davis, M.D., Pikeville
Lee Palmer, M.D., Louisville
Delmas M. Clardy, M.D., Hopkinsville, Chairman

Recommendations, Reference Committee No. 7

This committee met on May 26, 1960 at Lexington, to review and approve the activities of the Physicians Placement Service. Since the last report of this committee, the service has broadened its scope. Senior medical students, interns and residents are encouraged to register and give their intentions to type and location of practice. Contact is kept until the individual has located himself in practice. Specialists have been added to the listings and benefits of the service have increased many fold.

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Report of Representatives on Joint Commission for Improvement of Patient Care

The Joint Commission for the Improvement of the Care of the Patient met Tuesday, November 17, 1959, at Norton Memorial Infirmary, Louisville, Kentucky. Fourteen (14) members were present. Mr. Strawn Taylor gave an excellent report and discussion on the problems of the Aging in Kentucky.

Recently, it was proposed that the Council on Allied Medical Services, which is composed of three representatives from the Kentucky State Medical Association, Kentucky Dental Association, Kentucky Pharmacy Association, and the Kentucky Association of Registered Nurses, take over the functions of the Joint Commission for the Improvement of Patient Care. The Council of KSMA accepted the proposal, as did other organizations represented on the Commission, for the following reasons:

1. that the Joint Commission for the Improvement of Patient Care at the national level had been disbanded,
2. that at the state level there was a duplication in membership and in activities with the Allied Council on Medical Services, and
3. that the Council on Allied Medical Services was willing to assume the responsibilities of the Joint Commission for the Improvement of Patient Care.

Joint Commission for Improvement of Patient Care

Joseph Buskirk, M.D., Louisville
Carl Anderson, M.D., Ft. Thomas
Edward H. Ray, M.D., Lexington
Arthur T. Hurst, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 7

The Joint Commission "JC" for Improvement of Patient Care met one time in 1959. It was proposed

that the Council on Allied Medical Services take over the functions of the Joint Commission for the Improvement of Patient Care. The Council of KSMA accepted the proposal as did other organizations represented on the Commission.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the KSMA Representative to the State Practical Nurse Advisory Committee

As your KSMA representative to the State Practical Nurse Advisory Committee, the following report is made:

There were two meetings of the State Advisory Committee on Practical Nurse Education held—one on 27 January 60 at 1 p.m., CDT, in the Conference Room of the Department of Education in Frankfort, Kentucky. Your representative attended this meeting.

Miss Julia Beam, representing the Department of Education, presented to the group the status of the program as of November 30, 1959.

It was brought out in the discussion that 8% of the Licensed Practical Nurses were enrolled in extension courses during the fiscal year July 1, 1958 to July 1, 1959. Discussion then ensued regarding the extension courses and the need to interest more Licensed Practical Nurses in these extension courses.

It was moved and seconded that a report of the program since January 1, 1957 be compiled for this group. The motion was carried.

Mr. Fred Martin discussed future plans for the Practical Nurse Program under Public Law 911:

1. Three (3) or four (4) additional programs are to be added in the next two years.
2. Logical geographical areas were to be chosen for the establishment of these programs but Paducah, Owensboro, Covington, Laurel, Pulaski and Clay Counties were mentioned.
3. It was stated that the state matching money is now around $42,000.00. It was estimated that $84,000.00 for 1960-61 and $93,000.00 for 1961-62 matching funds for practical Nurses Training will be approved by the State Legislature.

There being no further business, the meeting adjourned at 3:35 p.m.

The second meeting was held 24 June 60 in Frankfort, Kentucky, and your representative was unable to attend this meeting because of conflicting appointments.

N. L. Bosworth, M.D.
KSMA Representative to the State Advisory Committee on Practical Nurse Education

Recommendations, Reference Committee No. 7

There were two meetings of the State Advisory Committee on Practical Nurse Education held in 1960. It was brought out in the meeting that 8% of the licensed practical nurses were enrolled in extension courses during the fiscal year July 1, 1958 to July 1, 1959. Future plans for the practical nurse program under Public Law 911 were discussed.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

Report of the Representative on State Tuberculosis Coordinating Council

The Kentucky State Coordinating Council for the control of tuberculosis is a voluntary body composed of representatives of the Kentucky State Department of Health, of the Kentucky State Tuberculosis Hospital Commission, of the Kentucky State Medical Association, of the Kentucky Tuberculosis Association, of the Kentucky State Association of Registered Nurses, of the Kentucky Hospital Association, of the Kentucky Board of Nursing Education and Nurse Registration and of the Kentucky Chapter of the American College of Chest Physicians. The function of this Council is to exchange information among representative organizations, to formulate policy, and to offer recommendations and advice. The Council has no authority.

There have been four meetings of the Kentucky State Coordinating Council for the Control of Tuberculosis during the past twelve months. The resume of the findings and actions of this Council that would be important to the Kentucky State Medical Association are as follows:

(1) October 20, 1959—The Council unanimously approved the following motion:
   (a) That the Council go on record as opposing the closing or the transfer of Waverly Hills to the State Tuberculosis Hospital Commission unless the City-County Board of Health can give reasons, including a financial report, stating why they feel they can no longer support the sanatorium;
   (b) That the Commission not take over the operation of Waverly Hills unless they can do so without curtailing any of the services offered by Waverly Hills or Hazelwood;
   (c) That no action be taken by the Commission until a thorough survey is made as to the actual number of cases needing hospitalization; and
   (d) That the City-County Board of Health state what will be done with the money they would save if the Commission were to take over the operation of Waverly Hills.

(2) December 21, 1959—A special report was made by Dr. Dorothy Magallon, acting Tuberculosis Control Officer with the State Department of Health, outlining an intensive coordinated effort to strengthen TB Control in Kentucky (details of this report and subsequent recommendations by Dr. Magallon are given in the report of the Associate Committee on Tuberculosis of the Kentucky State Medical Association).

(3) January 19, 1960—The Coordinating Council approved bills currently before the State Legislature as follows:
   (a) A bill to allow the State Tuberculosis Hospital Commission to redistrict the areas served by the state TB Hospitals so that one hospital would not have empty beds available while another hospital might have a waiting list.
   (b) A bill which would allow the State TB Hospital Commission to use funds for training certain personnel when and if the need arises.

   A bill which would allow the State TB Hospital Commission to treat histoplasmosis and other pulmonary fungus diseases in the State TB Hospitals was disapproved by the Coordinating Council. (As a matter of information, the state legislature passed this bill in spite of the Council's disapproval.)

(4) July 19, 1960—The Coordinating Council endorsed the recommendations set forth by Dr. H. L. McPheeters, Commissioner of the Department of Mental Health, concerning limited licensure for foreign graduates.

Representative on State Tuberculosis Coordinating Council
R. E. Mardis, M.D., Louisville

Recommendations, Reference Committee No. 7

The function of this council is to exchange information among representative organizations, to formulate policy and to offer recommendations and advice. The council has no authority. There have been four meetings of the Kentucky State Coordinating Council for the Control of Tuberculosis during the past twelve months. October 20, 1959, the council unanimously approved the following motion:

(a) That the Council go on record as opposing the closing or the transfer of Waverly Hills to the State Tuberculosis Hospital Commission unless the City-County Board of Health can give reasons, including a financial report, stating why they feel they can no longer support the sanatorium;

(b) That the Commission not take over the operation of Waverly Hills unless they can do so without curtailing any of the services offered by Waverly Hills or Hazelwood;

(c) That no action be taken by the Commission until a thorough survey is made as to the actual number of cases needing hospitalization; and

(d) That the City-County Board of Health state what will be done with the money they would save if the Commission were to take over the operation of Waverly Hills.

July 19, 1960—the Coordinating Council endorsed the recommendations set forth by Doctor H. L. McPheeters, Commissioner of the Department of Mental Health, concerning limited licensure for foreign graduates. The reference committee would like to refer this to the Board of Trustees for further study.

Mr. Speaker, I move the adoption and implementation of this section of the report. The motion was seconded and carried.

Report of the Rural Kentucky Medical Scholarship Fund

Over two hundred (200) medical students have received loans from the Rural Kentucky Medical Scholarship Fund since the first loan was granted in 1946. Taking care of this sizable program necessitates more and more time from KSMA Headquarters Office personnel and also requires considerable more attention on the part of the Scholarship Board of Trustees and particularly the Executive Committee of the Board.

The full Board of Trustees had its annual meeting on May 5 this year and approved applicants' requests for second, third and fourth-year loans. In addition, eleven first year loans were approved and four other applicants' requests were placed in reserve to receive loans provided sufficient funds become available. This year makes the first time qualifying applicants have been denied loans because of insufficient funds.

On August 4, the Executive Committee of the Board met and made decisions on matters relating to individual cases of scholarship recipients and reviewed the financial status of the Fund in detail. The Executive Committee has been corresponded with on many occasions and directed the Executive Secretary of the procedure to follow in handling various requests.

It is gratifying to report that sixty-two (62) scholarship recipients are *now practicing in qualifying areas that are approved by the Board.* Some recipients have completed both moral and financial obligation and moved from the rural section to take postgraduate training or to non rural areas in or out of the State. Of course, there are a few that are not living up to their obligation, but drastic steps are being taken in many cases to cope with them.

Members of the Board are most enthusiastic about the number of Rural Scholarship recipients that will be entering practice in the next few years. Nineteen (19) Fund recipients are now taking their internship, seventeen (17) will be eligible to graduate in 1961, thirty-one (31) in 1962, and sixteen (16) in 1963. As one member put it, the Fund is just now beginning to pay big dividends. Many nice articles have been written in newspapers and magazines praising the Scholarship program and we want to make special mention of the nice article that appeared in the June 1960 issue of the Rural Kentuckian Magazine.

Credit must be given where credit is due and to do this we must all be grateful and appreciative for the consideration given by the Honorable Bert T. Combs and the senators and representatives of the 1960 Legislature. A continuation of the $50,000 bi-annual appropriation was approved for the Fund from the Commonwealth, and in addition, Governor Combs made a loan (to be paid back if possible) of $10,000 from his emergency fund in order that approximately ten worthy freshmen can be granted loans this fall.

Rural Kentucky Medical Scholarship Fund
C. C. Howard, M.D., Glasgow
Chairman, Board of Trustees

Recommendations, Reference Committee No. 7

The report of this committee was studied and accepted.

Mr. Speaker, I move the adoption of this section of the report. Motion was seconded and carried.

The Report of the Representative to the Advisory Committee on Maternal and Child Health

I have attended the organizational meeting and must admit that relatively little has been done in this area. I have contacted some of the pediatricians in Owensboro and most of them have expressed a willingness to cooperate with the well baby clinic in Owensboro. Our local health board, of which I am a member, is also cooperating.

I feel that the problem will not be an insurmountable one in the metropolitan areas but am not so sure about getting the personnel in the rural areas and that, unfortunately, is where it is needed most.

W. H. Parker, M.D., Owensboro
Representative

(Secretary's Note—The Advisory Committee on Maternal and Child Health is not a KSMA committee but was appointed in November, 1959 by the State Health Commissioner. This Advisory Committee, composed of physicians and others who are in daily contact with health problems of mothers and children, serves as an advisory body to the Bureau of Maternal and Child Health. Dr. Parker is the KSMA representative on the Committee.)

Recommendations, Reference Committee No. 7

Mr. Speaker, I move the adoption of this section of the report. The motion was seconded and carried.

Mr. Speaker, I move the adoption of this report as a whole. The motion was seconded and carried.

Reference Committee No. 7
Benjamin Boone, M.D., Louisville, Chairman
Robert S. Tillett, M.D., Louisville
W. K. Skaggs, M.D., Taylorsville
Elias Futrell, M.D., Cadiz
Douglas Jenkins, M.D., Richmond

Unfinished Business

It is stated that there was no unfinished business at this time. The speaker expressed appreciation for the spirit of cooperation and good will of the delegates.

Election of Officers

A motion was made, seconded and carried that the nominations to fill the vacant offices for the 1960-61 associational year be closed, and the following nominees were presented:

President-Elect	Gaithel L. Simpson, M.D., Greenville
Vice-Presidents:	
(Central)	Foster Coleman, M.D., Louisville
(Eastern)	Wendell Lyon, M.D., Ashland
(Western)	Thomas Gilbert, M.D., Bowling Green
Delegate to the AMA:	Robert Long, M.D., Louisville
Alternate Delegate to the AMA:	George P. Archer, M.D., Prestonsburg

After each nomination was presented, the speaker called for nominations from the floor. None were made in any instance, and each nominee was elected individually. There were no dissenting votes.

The following men were asked to escort the new president-elect to the rostrum: Charles Johnson, M.D., David Cox M.D., and John Handley, M.D., This was done amid a standing ovation, after which Doctor Simpson made brief remarks.

Election of Trustees

Fifth District	Carlisle Morse, M.D., Louisville
Sixth District	John P. Glenn, M.D., Russellville
Eighth District	Dexter Meyer, M.D., Covington
Tenth District	Douglas E. Scott, M.D., Lexington
Eleventh District	Hubert Jones, M.D., Berea
Fifteenth District	Keith P. Smith, M.D., Corbin

The same procedure followed in electing the general officers was followed in the electing of the trustees.

Nominations for Board of Directors, Kentucky Physicians Mutual, Inc.

The following list of nominees for the Board of Directors, Kentucky Physicians Mutual, Inc. was submitted at this time and received for information only:

Richard J. Rust, M.D., Newport
J. Duffy Hancock, M.D., Louisville
Coleman C. Johnston, M.D., Lexington
John Dickinson, M.D., Glasgow
John D. Gordinier, M.D., Louisville
Thomas O. Meredith, M.D., Harrodsburg
Howard Frisbie, M.D., Stanford
Garnett J. Sweeney, M.D., Liberty
Charles Mahaffey, M.D., Danville
Clyde C. Sparks, M.D., Ashland
Wyatt Norvell, M.D., New Castle
J. S. Williams, M.D., Nicholasville
William C. Hambley, M.D., Pikeville

Election of 1960 Nominating Committee

The nominating committee to serve at the 1961 Annual Meeting was duly elected as follows:

A. D. Butterworth, M.D., Murray
M. C. Darnell, M.D., Lexington
Russell L. Hall, M.D., Prestonsburg
William E. Oldham, M.D., Louisville
Walker M. Turner, M.D., Paducah

At this time, Richard G. Elliott, M.D., Lexington, was installed into office by the administration of the oath of office by the chairman of the Board of Trustees. The new president's first official act was that of presenting the past-president's key to the retiring president, Doctor Abell, who expressed his appreciation at this time for the cooperation shown during his presidency. Doctor Elliott thanked the members of the House for the high honor bestowed upon him.

A motion was then made and seconded that the House of Delegates go on record as expressing its deep appreciation for the manner in which the speaker, Doctor Overstreet, had carried out the business of the sessions of the 1960 House of Delegates. The motion carried.

There being no further business, a motion was made, seconded and carried that the 1960 meeting of the House of Delegates adjourn at 9:05 p.m.

●

Medical History Of War Offered

Fifteen volumes in the series, "History of the Medical Department, United States Army, in World War I," have been published and are now available to the public at a modest cost, *The Journal* has been notified by Lt. Col. Leonard L. Collier, Chief of the Promotion Branch, Medical Services Corps. Forty-eight volumes have been programmed for the series, with Lt. Gen. Leonard D. Heaton, the Army Surgeon General, directing their preparation, publication and distribution.

The set of 15 volumes may be purchased for $66.50 from the Superintendent of Documents, Government Printing Office, Washington 25, D. C. Individual volumes also are available. Commanding officers of medical units may requisition copies for their Medical Units libraries by submitting DA Form 17 directly to the Historical Unit, U. S. Army Medical Service, Washington 12, D. C.

CPC's of the MGH In Book Form

Fifty selected cases from the Clinicopathological Conferences of the Massachusetts General Hospital have been brought out in book form. Culled from more than 3,000 CPC's published in the New England Journal, the articles present a wide range of diagnoses and a variety of viewpoints from many discussants. The book was edited by Benjamin Castleman, M.D., clinical professor of pathology at Harvard Medical School, and H. Robert Dudley, Jr., M.D., instructor in pathology at Harvard. Published by Little, Brown and Company, Boston, it contains 352 pages and 153 illustrations and is priced at $12.50.

Radiological Health Director Named

Kentucky has a new director of radiological health. He is Morris Martin, formerly a physicist and instructor in radiological health for the U.S. Public Health Service at Cincinnati.

The new division in the State Department of Health was created by an executive order of Governor Bert T. Combs on September 1.

ORGANIZATION SECTION

County Society Officers Conference Set April 6 In Lexington

Plans are well advanced for the 11th Annual County Society Officers Conference scheduled for Thursday, April 6. 1961, in Lexington, KSMA President Richard G. Elliott, M.D., Lexington, has announced. The meeting will be held at the Phoenix Hotel.

Speakers from both coasts have accepted KSMA's invitation to appear on the program.

Watch the January issue of *The Journal* for further details on the conference. Doctor Elliott urges you to mark your calendar now and plan to attend.

Dr. McCarty of Louisville Named SMA President-Elect

A. Clayton McCarty, M.D., Louisville, was named president-elect of the Southern Medical Association at its annual meeting in St. Louis in early November. He served the association as vice-president the past year.



Dr. McCarty

This is the second high medical office that has come to the Louisville internist in recent months, the American Geriatrics Society having honored him with its presidency.

Doctor McCarty formerly served the Southern Medical Association as Councilor from Kentucky. He is a former chairman of the KSMA Associate Committee on Problems of the Aged, a former vice-president of KSMA, and a past president of the Jefferson County Medical Society.

Doctor McCarty also heads the Kentucky Advisory Committee and the Selective Service System.

U. L. Medical School Gets Grants Totaling $372,788

Grants totaling $372,788 have been made to the University of Louisville School of Medicine and its professors in recent weeks.

A $97,146 grant was approved by the United States Public Health Service to help pay for equipment in the new medical-dental research building planned for the Medical Center in Louisville. A previous grant of $1,293,000 was awarded by the Service for the building construction.

A grant of $225,642 was made to the Department of Pharmacology by the Public Health Service. The grant, the largest ever received by the department, will extend from 1961 to 1966. Most of the money will be used for stipends for fellowships, with the remainder going for laboratory facilities and an additional instructor on the pharmacology staff, according to Peter Knoefel, M.D., department chairman.

Paul G. LeFevre, M.D., professor of pharmacology, has received $50,000 from the National Science Foundation to study the interactions of blood cells and life-giving sugars.

Dr. Norvell Elected by Council On Allied Medical Services

Wyatt Norvell, M.D., New Castle, was elected chairman of the Council on Allied Medical Services in Kentucky at a meeting in Frankfort on October 24.



Dr. Norvell

Moved up from secretary to vice-chairman was Miss Nelle Weller, Louisville, executive secretary of the Kentucky State Association of Registered Nurses. A. B. Coxwell, D.M.D., Louisville, secretary-treasurer of the Kentucky Dental Association, was named secretary.

The Council, which is made up of representatives of the dental, hospital, nursing and pharmaceutical professions, was active in promoting indigent medical care legislation passed by the 1960 General Assembly.

Dr. Pickar Heads Chest Physicians

Daniel Pickar, M.D., Veterans Administration Hospital, Louisville, is the new president of the Kentucky Chapter, American College of Chest Physicians.

William H. Anderson, M.D., Harlan, was elected vice-president instead of president, as inadvertently reported in the November issue of *The Journal.*

KSMA Enrolls 10 New Members

Ten Louisville M.D.'s have become members of the Kentucky State Medical Association since *The Journal's* last report. They are: James E. Alvey, Orville S. Clark, Robert G. Cooper, James W. Dorton, Ronald L. Levine, James A. Marshall, Alfred E. Mattox, Marvin Murray, James S. Rieser and Russell F. Scalf.



Representatives of various groups interested in the McKee project are pictured here with the new physician, Leon W. Bowman, M.D., seated. Standing, from left, are: C. C. Howard, M.D., Glasgow, chairman of the Rural Kentucky Medical Scholarship Fund; Mrs. James H. Hays, Jr., past president of the McKee Woman's Club; John D. Austin, Chicago, regional director of the Sears-Roebuck Foundation; J. P. Sanford, executive secretary of the Kentucky State Medical Association; Joe Miller, Chicago, field representative of the American Medical Association; Walter Portteus, M.D., Franklin, Ind., the AMA member of the board of trustees of the Sears-Roebuck Foundation, and Hubert Jones, M.D., Berea, trustee of KSMA.

New $24,000 Doctor's Building At McKee Is Dedicated

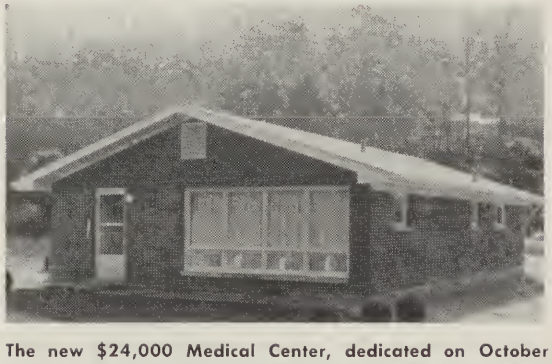
The small Eastern Kentucky county seat of McKee made medical news October 28, when it dedicated a new $24,000 doctor's building and welcomed a young physician as the first occupant. The community had been without a doctor for several years.

The project marks the first time the Kentucky State Medical Association, the Rural Kentucky Medical Scholarship Fund and the Sears-Roebuck Foundation have worked together with a community to establish a medical center and locate a doctor.

Tribute to the Jackson County town and its people was paid by Congressman Eugene Siler, Williamsburg, principal speaker at the dedication. Praise also came from representatives present from the medical profession of Kentucky, Indiana and Illinois.



Tribute to the McKee community was paid by Congressman Eugene Siler, right, principal speaker at the dedication. He spoke on "Wise Community Builders." With him are, from left, State Senator Fred Bishop of Teges, Clay County; C. C. Howard, M.D., Glasgow, and Mrs. Siler.



The new $24,000 Medical Center, dedicated on October 28, is a 13-room brick structure that is modern in every respect, from air conditioning to electric heating. It has an emergency room, recovery room, delivery room, two examining rooms, laboratory, X-ray and dark room, waiting and reception rooms and an office for the physician.

To C. C. Howard, M.D., Glasgow, chairman of the Rural Kentucky Medical Scholarship Fund, goes credit for the original idea for the project. Driving through McKee a couple of years ago, he noted its need of a physician and decided that something should be done to remedy the situation.

With the backing of the KSMA and the Sears-Roebuck Foundation, he presented a plan to the McKee people. First, they were asked to conduct a survey to show that the community could support a doctor. The McKee Woman's Club, headed by Mrs. J. H. Hays, Jr., agreed to make the survey. The



Ribbon-cutting ceremonies, formally opening McKee's new doctor's building, were in charge of Mrs. James H. Hays, Jr., past president of the McKee Woman's Club, which backed the project. Looking on were: Doctor Bowman, left; Luther Farmer, McKee, president of the Jackson County Development Association, which built the new structure, and Mrs. Bowman.

New $24,000 Doctor's Building At McKee Is Dedicated

(Continued)

next step was to raise funds for construction of the doctor's building by selling stock shares to local residents.

When the time came to select a physician, the KSMA Physicians Placement Service and the Rural Scholarship Fund made suggestions. The choice fell on Leon W. Bowman, M.D., a native of adjoining Owsley County, who was then interning at Springfield City Hospital, Springfield, Ohio. The young general practitioner was graduated from the University of Louisville School of Medicine in 1959.

Kentucky physicians attending the dedication were: Doctor Howard, Glasgow; John Archer, M.D., Prestonsburg; J. S. Williams, M.D., Nicholasville; Hubert Jones, M.D., Berea; John B. Rypstra, M.D., Annville; Dillard I. Turner, M.D., London; Dwight Blackburn, M.D., Berea; Edward M. Thompson, M.D., Frankfort; Russell Hall, M.D., Prestonsburg; R. E. Pennington, M.D., London, and R. G. Webb, M.D., Livingston.

Others present included: State Senator Fred Bishop, Manchester; John Austin, Chicago, regional representative of Sears-Roebuck Foundation; Walter Portteus, M.D., Franklin, Ind., medical advisory board and AMA representative, Sears-Roebuck Foundation; Robert L. Johnson, director of community services, University of Kentucky Medical Center; E. M. Josey, Frankfort, executive of the Kentucky Pharmaceutical Association; Joe Miller, Chicago, AMA field representative, and John D. Whisman, Hazard, executive director of the Eastern Kentucky Regional Planning Commission.

M. D.'s Head Heart Association

Robert L. McClendon, M.D., Louisville, was installed as president of the Louisville and Jefferson County Heart Association at its annual meeting on November 4. Walter S. Coe, M.D., Louisville, was named president-elect to succeed him in 1961.



Bobbie R. Grogan, right, KSMA's director of field services, was responsible for getting the people of McKee and their new doctor together. He suggested Doctor Bowman, shown here with Mrs. Bowman, as a possible choice.

Disabled Workers At Any Age Now Entitled to Benefits

Under the 1960 changes in the Social Security law, the age limitation has been removed for workers entitled to disability insurance benefits, according to Hugh A. McNary, manager of the Social Security Administration's District Office in Louisville. The Mills-Kerr bill passed by the 1960 bobtailed session of Congress eliminated the 50-year age requirement.

Until now, a disabled worker under 50 could apply to have his Social Security record frozen, but he and his family could not be paid monthly benefits until he reached the age of 50.

Mr. McNary said his office had contacted disabled persons who had already had their Social Security records frozen, and that benefit checks for the month of November would be mailed early in December.

For disabled workers under 50 who have never applied to have their Social Security records frozen, he suggests that they get in touch with his office to find out if they are eligible for monthly benefits. Persons who have worked under Social Security for at least five out of the 10 years just before they became disabled may apply for benefits.

Dr. Canter Heads Health Council

Nathan Canter, M.D., Owensboro, a member of the KSMA Committee on Rural Health, was elected chairman of the Kentucky Rural Health Council at the 1960 Kentucky Rural Health Conference at Morehead State College on October 27.

The 1961 Rural Health Conference, which will be sponsored by the Council, will probably be held either at Murray or Kentucky Dam Village.



Mrs. Eva Ray Wunderlich, who is retiring December 31 as director of the Division of Medical Licensure, State Board of Health, is shown in her Frankfort apartment with the silver tea service presented to her by board members. She has been with the board 25 years.

Mrs. Wunderlich, Medical Licensure Director, to Retire Dec. 31

Mrs. Eva Ray Wunderlich, known and loved by literally hundreds of Kentucky physicians, will retire December 31 as director of the Division of Medical Licensure of the State Board of Health.

During the 25 years that she has held this position, her ready wit and prompt and efficient service have endeared her not only to the medical profession but to the large number of people who contact her in the normal course of business.

The KSMA Headquarters Office staff is indebted to her for the splendid service she has rendered it and for her valuable assistance at the registration desk during the Annual Meetings.

Replacing Mrs. Wunderlich will be Mrs. Fred Caudill, Louisville, whose late husband was epidemiologist for the State Department of Health. For the past 10 years Mrs. Caudill has been employed by the Kentucky Dental Association.

A native of Hadley in Warren County, Mrs. Wunderlich attended Western Normal School, Bowling Green, where she majored in music. Her first job was with Western Union in Bowling Green. From there she went to Honolulu to work for R. C. A. for several years. She joined the State Board of Health in 1935, training under Miss Mamie Sullivan for about 10 years.

The Division of Medical Licensure has issued 4,240 medical licenses during her tenure of office. It averages about 200 a year.

Mrs. Wunderlich was honored by State Board of Health members with a silver tea service presented for them by E. M. Howard, M.D., Harlan, board president.

Drs. Gordinier, Norvell Elected To KPM Board Of Directors

Two physicians and one layman were elected to serve on the board of directors of Kentucky Physicians Mutual, Inc., at the annual meeting of the members October 20 at the headquarters building of Blue Cross-Blue Shield Plans in Louisville. Kentucky Physicians Mutual is the Blue Shield Plan for Kentucky.

John D. Gordinier, M.D., Louisville, and Wyatt Norvell, M.D., New Castle, were named directors for a three-year term. Leonard Campbell, president of Second National Bank, Ashland, was elected to fill the term of a lay member expiring in 1962.

The following physicians were re-elected for three years: Richard J. Rust, Newport; J. Duffy Hancock, Louisville; Coleman C. Johnston, Lexington; John Dickinson, Glasgow; Thomas O. Meredith, Harrodsburg, and Garnett J. Sweeney, Liberty.

Lay members re-elected for three years were: S. A. Ruskjer, J. E. Stanford and J. P. Sanford, all of Louisville.

Dr. Lynn Accepts Mayo Post

Hugh B. Lynn, M.D., associate professor of surgery at the University of Louisville School of Medicine and chief surgeon at Children's Hospital, Louisville, has resigned to accept a position at the Mayo Clinic, Rochester, Minn. He will head a new section in pediatric surgery aimed at correlating all the surgical cases among children at the clinic.

Doctor Lynn has been in Louisville seven and a half years.



Mrs. Earl W. Roles, Prospect, left, new president of the Woman's Auxiliary to KSMA, discusses the year's program with the president-elect, Mrs. Guy Morford, Owensboro, at the annual fall meeting of their board at the Frankfort Country Club on November 10. The meeting was attended by more than 50 members. This picture was made after Mrs. Charles B. Johnson, Russell, immediate past president, had left the club.



The new and retiring chairmen of the Kentucky Rural Health Council, Nathan Canter, M.D., left, Owensboro, and Mitchell B. Denham, M. D., Maysville, took time out from the Morehead conference for refreshments served by the district "Dairy Princess," Miss Judy Gerhard, Brooksville. Milk was furnished by the State Dairy Association.



A Kentucky Colonel commission was presented by Gov. Bert T. Combs to Mrs. T. E. Roberts, Louisville, in recognition of her rural-health work. Mrs. Roberts has served as secretary-treasurer of the Rural Health Council since its beginning, was re-elected. Governor Combs was the evening speaker at the conference.

Rural Health Conference Draws 174 To Morehead

Despite inclement weather, a total of 174 persons registered for the eighth annual Kentucky Rural Health Conference at Morehead State College on October 27. Thirty counties and a number of other states were represented at this conference, the first held in the eastern part of the state.

Nathan Canter, M.D., Owensboro, was elected chairman of the Kentucky Rural Health Council which was founded in 1951 by the KSMA. He succeeds Mitchell B. Denham, M.D., Maysville, who held the office two years.

Miss Viola Hansen, chairman of the Home Economics Department of the University of Kentucky Agricultural Experiment Station, was named vice-chairman. Mrs. T. E. Roberts, Louisville, who has served as secretary-treasurer since the Council's organization, was re-elected for another year. In recognition of her work in promoting rural health, Mrs. Roberts was made a Kentucky Colonel by Governor Bert T. Combs at this conference.

Guest speakers included Governor Combs and Dr. Adron Doran, president of Morehead State College. The program also featured three panel discussions.

On Wednesday night, October 26, the Kentucky State Medical Association was host at a dinner for Morehead students who are planning medical careers. William H. Cartmell, M.D., Maysville, presided at the program which included showing of the film, "I Am a Doctor."

The KSMA is one of 24 member organizations of the Kentucky Rural Health Council.

John E. Cotthoff, M.D., Kuttawa, will begin a two-year residency in internal medicine at St. Thomas Hospital, Nashville, Tenn., on January 1.

State Board Rules Prescription Needed for Dihydrocodeinone

The following notice was sent recently to all physicians in Kentucky by the State Board of Health:

"The State Board of Health has repealed its regulation which exempted medical preparations containing one sixth (1/6) gr. of dihydrocodeinone from the provisions of the state narcotic act. This action by the board, which will be effective on October 7, 1960, requires that products containing dihydrocodeinone be dispensed only upon the written or oral prescription of a licensed practitioner. The board took this action because of numerous complaints that narcotic addicts were substituting dihydrocodeinone preparations for more potent narcotic drugs. Some of the most common trade names for dihydrocodeinone preparations are: Cosanyl, Tussar, Endotussin, Coricidin Syrup, Bucol, Deka, and Imprints.

"Certain codeine products, specified in KRS 218.080, are the only remaining exempt narcotic preparations that may be obtained without a prescription.

"All pharmacists should immediately remove all products containing dihydrocodeinone to the prescription department."

Nurses Elect Mrs. Gavirati

Mrs. Apolonia Gavirati, Dawson Springs, was elected president of the Kentucky State Association of Registered Nurses at the group's annual meeting in Louisville October 21.

Mrs. Marjorie Glaser, Louisville, retains the office of first vice-president and Miss Yvonne Fleming, Hopkinsville, remains as secretary. Other officers elected were: Mrs. Bess Kuiper, Lexington, second vice-president; Miss Kathleen O'Leary, Louisville, treasurer, and Mrs. Lola Belle Akin, Paintsville, and Miss Martha Kern, Danville, directors.

Postgraduate Medical Offerings Listed Through March

Twelve postgraduate opportunities in March are included in a listing announced by the KSMA Postgraduate Medical Education Office. Scheduled in four states, the meetings are within reach of Kentucky physicians.

Detailed information on the courses may be obtained from the Postgraduate Medical Education Office, 104 West Chestnut Street, Louisville 2, Ky. The telephone number is JUniper 7-7135.

The complete listing through March follows:

December

15	John N. Norton Memorial Infirmary Medical Seminar; postgraduate course at the Infirmary in Louisville.
15-17	Postgraduate course, "Consultations On Problems In Practice"; University of Oklahoma Medical Center, Oklahoma City 4.
20	State Tuberculosis Hospital Journal Club meeting, 6 p.m.; Tissue Club meeting, 7 p.m.; State Tuberculosis Hospital, District 2, Louisville.

December through January—Tentative intermittent course (12 weeks, one-half day each week) on EKG Interpretation; Louisville General Hospital.

January

6	Postgraduate course, "Ophthalmology"; University of Texas Southwestern Medical School, Dallas.
19-20	Postgraduate course, "Obstetrics & Gynecology"; University of Nebraska College of Medicine, Omaha.
23-27	Postgraduate course, "Pediatrics, Obstetrics and Gynecology"; University of Tennessee, Memphis.
25-27	Postgraduate course, "Clinical Hematology"; University of Tennessee College of Medicine, Memphis 3.

February

6-7	Postgraduate course, "Electrocardiology"; Course I, University of Nebraska College of Medicine, Omaha 5.
6-7	Annual Surgical Meeting (Tentative); Dr. M. Stanley, Louisville.
20-21	Postgraduate course, "Psychiatry"; University of Michigan Medical Center, Ann Arbor.

March

6-10	Postgraduate course, "Pediatrics"; University of Tennessee, Memphis.
8-9	Postgraduate course, "Hematology," (Tentative) Lexington, Ky.
9-10	Postgraduate course, "Infertility and Endocrinology"; University of Michigan Medical Center, Ann Arbor.
13-14	Postgraduate course, "Neurology, Clinical"; University of Michigan Medical Center, Ann Arbor.
15-17	Postgraduate course, "Anesthesiology"; University of Tennessee, Memphis 3.
16-17	Postgraduate course, "Gastroenterology"; University of Nebraska, College of Medicine, Omaha 5.
20	Senior Day Program—Sponsored by the KSMA, Jefferson County Medical Society, and the University of Louisville; afternoon and evening, Kentucky Hotel.
20-24	Postgraduate course, "Electrocardiography"; University of Tennessee, Memphis 3.
22-23	Symposium on Heart Disease, sponsored by the Heart Association, and the University of Louisville; Brown Hotel, Louisville.
23	Pediatric Society meeting; Louisville, Sheraton Hotel.
24	Postgraduate course, "Physical Medicine"; University of Nebraska College of Medicine, Omaha 5.
24-25	Kentucky Chapter, American College of Surgeons, Annual Meeting; Louisville, Brown Hotel.

County Society Reports

McCracken County

The McCracken County Medical Society at its October meeting voted that school-teacher applicants for retirement disability should be given the choice of physician. The secretary was directed to inform the KSMA Headquarters Office of this action.

On the executive committee's recommendation that the society send one of its delegates to the AMA Clinical Meeting in Washington, D. C., in November, Walter Johnson, M.D., was named delegate and Walker Turner, M.D., alternate delegate.

The public relations committee was instructed to study the Rural Kentucky Medical School Scholarship Fund program and present material on the subject to high school students and other interested persons in the area.

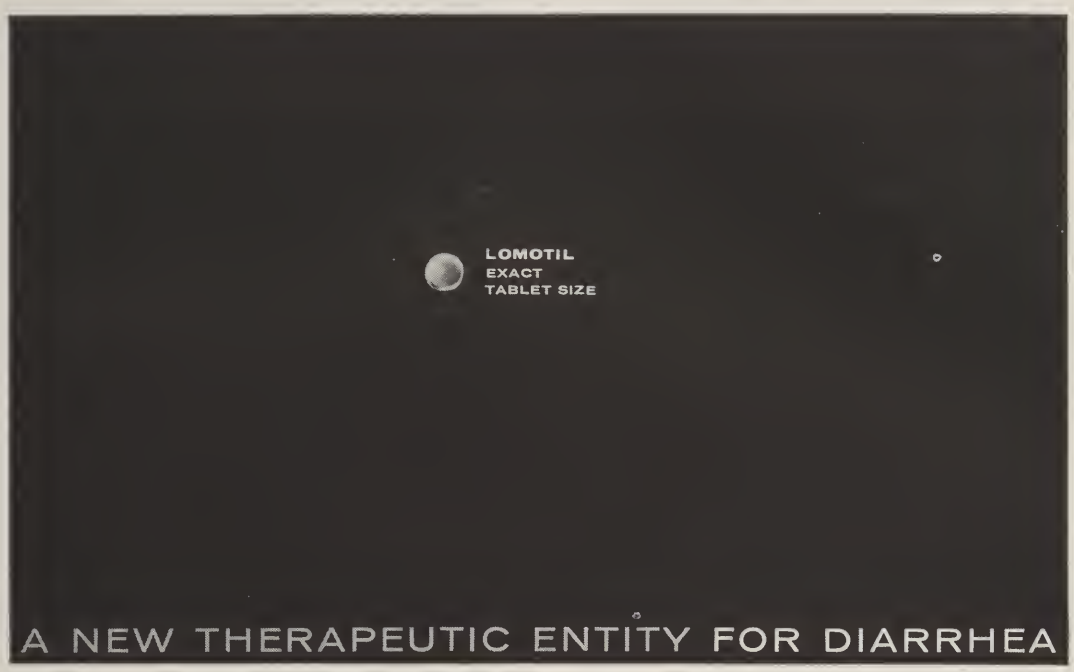
Doctor Johnson, chairman of the public relations committee, urged all members to assist in every way possible in getting out the voters on Election Day.

The insurance committee was asked to study the possibility of obtaining a group insurance program, possibly with Blue Cross-Blue Shield.

Theodore T. Myre, M.D., was unanimously accepted as a member on transfer from the Vanderbaugh County Society, Evansville, Ind.

The scientific program was presented by Martin S. Kleckner, M.D., Paducah, speaking on "The Question of Values."

The University of Louisville School of Medicine is sending its medical students to high school—to attract future doctors. In a recruiting drive the med students will go into the high schools of the state in an attempt to interest high school students in careers in medicine.



A NEW THERAPEUTIC ENTITY FOR DIARRHEA

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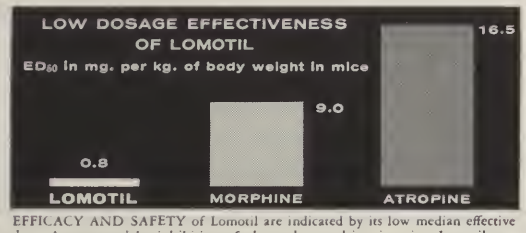
SELECTIVELY LOWERS PROPULSIVE MOTILITY

LOMOTIL represents a major advance over the opium derivatives in controlling the propulsive hypermotility occurring in diarrhea.

Precise quantitative pharmacologic studies demonstrate that Lomotil controls intestinal propulsion in approximately 1/11 the dosage of morphine and 1/20 the dosage of atropine and that therapeutic doses of Lomotil produce few or none of the diffuse untoward effects of these agents.

Clinical experience in 1,314 patients amply supports these findings. Even in such a severe test of antidiarrheal effectiveness as the colonic hyperactivity in patients with colectomy, Lomotil is effective in significantly slowing the fecal stream.

Whenever a paregoric-like action is indicated, Lomotil now offers positive antidiarrheal control . . . with safety and greater convenience. In addition, as a nonrefillable prescription product, Lomotil offers the physician full control of his patients' medication.



EFFICACY AND SAFETY of Lomotil are indicated by its low median effective dose. As measured by inhibition of charcoal propulsion in mice, Lomotil was effective in about 1/11 the dosage of morphine hydrochloride and in about 1/20 the dosage of atropine sulfate.

PRECAUTION: While it is necessary to classify Lomotil as a narcotic, no instance of addiction has been encountered in patients taking therapeutic doses. The abuse liability of Lomotil is comparable with that of codeine. Patients have taken therapeutic doses of Lomotil daily for as long as 300 days without showing withdrawal symptoms, even when challenged with nalorphine.

Recommended dosages should not be exceeded.

DOSAGE: The recommended initial dosage for adults is two tablets (5 mg.) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. (1/2400 gr.) of atropine sulfate to discourage deliberate overdosage.

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Research in the Service of Medicine

48 Kentucky M.D's Register At SMA Annual Meeting

KSMA members attending the Southern Medical Association's annual meeting October 31-November 3 in St. Louis, according to the "Daily Bulletin" published during the meeting, were:

October 31

Allen, George S., Louisville.
Briggs, Philip D., Louisville.
Cawein, Madison, Lexington.
Gumbert, G. M, Jr., Lexington.
Massie, W. K, Lexington.
McMunn, G. E., Eminence.
Starr, Silas H., Louisville.

November 1

Baker, S. S, Louisville.
Beatty, Oren A., Louisville.
Bryan, Paul A., Ashland.
Buttermore, Willard M., Corbin.
Castle, Eugene A., Madisonville.
Crice, Thomas J., Louisville.
Denham, Ralph M., Louisville.
Ehrman, Frederick C., Louisville.
Eskind, Harold G., Louisville.
Fine, Lewis, Lewisville.
Friesen, Carl M., Lexington.
Gordinier, John D., Louisville.
Graves, G. Y., Bowling Green.
Hancock, J. Duffy, Louisville.
Haynes, Douglas M., Louisville.
Heisel, C. N., Covington.
Johnson, Charles B., Russell.
Johnson, Walter R., Paducah.
Johnston, David H., Lexington.
Jones, Conrad H., Murray.
Jones, David L., Fulton.
Jones, Max P., Louisville.
Joslin, Albert H., Louisville.
Kleckner, Martin S., Jr., Paducah.
Kirkpatrick, Charles L., Middlesboro.
Leavell, Ullin W., Jr., Lexington.
Lich, Robert, Jr., Louisville.
Lockwood, K. L., Outwood.
McCarty, A. Clayton, Louisville.
Marshall, J. B., Louisville.
Monroe, R. F., Louisville.
Morgan, A. R., Mayfield.
Parker, Joseph B., Jr., Lexington.
Rutledge, Charles C., Hazard.
Ryan, James E., Louisville.
Shepard, Robert D., Lexington.
Sprague, John S., Lexington.
Stevens, David B., Lexington.
Warren, Sam, Lexington.
Witten, Carroll L., Louisville.
Witten, Raleigh E., Louisville.

Charles B. Wathen, M.D., has transferred his practice from Owensboro to Hardinsburg.

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NEWS ITEMS

Maurice M. Best, M.D., and **Charles H. Duncan, M.D.,** Louisville, were guest speakers at the American Heart Association's annual scientific meeting in St. Louis in October.

Ben F. Bradford, M.D., has opened an office in the Medical Arts Building, Paducah, for the practice of internal medicine. A native of Alexandria, La., he earned his medical degree from Louisiana State University in 1948, interned at the USPHS Hospital, Staten Island, N.Y., and took residency training at the USPHS Hospital, New Orleans. He saw service in the U.S. Navy, 1943-1946, and the USPHS, 1948-1954.

Jane Triplett Carswell, M.D., has started practice at Cumberland in association with the Cumberland Valley Medical Group. She received her M.D. degree from the Medical College of Virginia in 1958 and took her internship at hospitals there. Doctor Carswell is a native of Ralford, N. C.

Frank B. Crawford, Jr., M.D., a native of Aberdeen, Miss., has started practice in Paducah in association with **Casey J. Purdy, M.D.** His specialty is radiology. Doctor Crawford was graduated from Bowman Gray School of Medicine, Winston-Salem, N. C., in 1950, interned at John Gaston Hospital, Memphis, Tenn., and took residency training at Methodist Hospital, Memphis. He served as a pilot in the Army Air Force from 1942 to 1945 and as a captain in the Medical Corps from 1951 to 1953. He formerly practiced in Mississippi for four years.

Mitchell B. Denham, M.D., Maysville, addressed the Pre-Medical Club of Eastern State College on October 10. He is an alumnus of the college.

Helen M. Gray, M.D., has opened an office in the Francis Building in Louisville, limiting her practice to child psychiatry. She has been on the staff of the Louisville Child Guidance Clinic the past two years and will continue this work on a part-time basis. Doctor Gray was born in Webster Groves, Mo., and received her medical degree from Washington University, St. Louis, in 1950, after which she served an internship in pediatrics at the University of Minnesota hospitals and a residency in pediatrics at St. Louis Children's Hospital. Other postgraduate training included residencies in psychiatry at Grassland Hospital and New York Hospital and a two-year fellowship in child psychiatry at the Louisville Child Guidance Clinic.

Andrew S. Wachtel, M.D., has joined the staff of the Veterans Administration Hospital, Lexington. His specialty is psychiatry. Born in Jersey City, N. J., Doctor Wachtel was graduated from Baylor University Medical School in 1950, interned at the VA Hospital, Houston, Texas, and was a resident in psychiatry at Baylor from 1957-60. He served six years in the U. S. Army Medical Corps with the rank of captain and practiced medicine in Owosso, Mich., three years.

Paul R. Kleykamp, M.D., who has been located at Ashland since 1953, has given up private practice to take the post of works physician at Ashland Armco. Doctor Kleykamp was graduated from the Medical College of Virginia in 1952. He served three years in the U.S. Navy during World War II.

Sam Paris, M.D., Bowling Green, was elected grand junior warden of the Grand Lodge of Kentucky, Free and Accepted Masons, at the lodge's 160th annual communication held in Louisville in October. This places him in line to become grand master in three years. Doctor Paris has held numerous offices in Masonic organizations.

Norman A Parrott, M.D., a Diplomate of the American Board of Dermatology, has opened offices in the Medical Arts Building, Paducah. Born in Harrodsburg, Doctor Parrott received his medical degree from the University of Louisville School of Medicine in 1948 and interned at Aiea Height and Tripler General Hospital, Oahu, T. H. He was a resident at St. Luke's Hospital, Milwaukee, 1949-50; assistant in dermatology at Vanderbilt Clinic, Columbia University, 1955-57; preceptee-dermatology, Dr. J. Lowry Miller, New York, 1955-57, and a fellow in dermatology at Presbyterian Hospital, Columbia University, 1957-58. He has served three times in the U.S. Navy, attaining the rank of lieutenant in the Medical Corps.

E. T. Runyon, M.D., Ewing physician, was honored by the Ewing Men's Club at a reception at his home on October 16. Doctor Runyon was presented a Kentucky Colonel commission by State Representative Herbert Fern, acting on behalf of Governor Combs.

John R. Stevie, M.D., has opened an office in his native Covington and will specialize in obstetrics and gynecology. A 1953 graduate of the University of Louisville School of Medicine, he interned at St. Elizabeth Hospital, Covington, after which he was in general practice in Covington from 1954 to 1956. He later took four years of residency training at Veterans Hospital and General Hospital in Louisville. Doctor Stevie served in the U. S. Air Force from 1942 to 1946, attaining the rank of lieutenant.

Norman E. White, M.D., a 1959 graduate of the University of Louisville School of Medicine, has started practice in Prestonsburg. A Louisvillian, Doctor White served 18 months in the U.S. Air Force. He interned at Kentucky Baptist Hospital, Louisville.

James O. Willoughby, M.D., has opened an office in Bowling Green, after completing a three-year residency in ophthalmology at Henry Ford Hospital, Detroit. Doctor Willoughby, a native of Butler county, was graduated from the University of Louisville School of Medicine in 1947, interned at Louisville General Hospital, and practiced general medicine in Shepherdsville from 1949 to 1954. He was in the U. S. Navy from 1955 to 1957, leaving the service with the rank of lieutenant commander, USNR.

Student AMA

On Tuesday, November 8th, the people of Louisville rejected a proposed $7,000,000 bond issue for the University of Louisville by the overwhelming majority of nearly 2 to 1. This proposal was an expanded version of a $2,700,000 bond issue defeated in 1958. While the 1958 proposal was actually approved by 1,700 votes (being defeated because this fell short of the 2/3 majority required), the bond issue this year was rejected by every ward. It is true that the 1960 defeat was tempered by various side-issues and by an unfavorable attitude on the part of the mayor, but the vast margin of defeat would seem to require further explanation.

The majority of this money—approximately 4 million dollars—was to have gone toward a new teaching building for the medical and dental schools. The remainder was to have been used for improvements on Belknap Campus.

Above all else, there seemed to be a lack of understanding on the part of the general public regarding the great benefit to be derived through a stronger university; a failure to see that this city is entering an exciting phase of development of which the streamlining of an outdated and inadequate medical center is an integral part; a failure to realize that better trained physicians and dentists mean a higher standard of medical and dental care in this very area. Many persons wanted to "let the university worry about it," not realizing that the strength of this institution and its progress mirror the strength and progress of the city—and that the city is no stronger than its citizens.

From a more practical point of view, it was virtually certain that federal funds would be appropriated to match the city's outlay—at least that 4 million dollars earmarked for the professional schools. As a result of the defeat a more progressive city will reap the benefits of our own tax money—the tax money which we failed to bring back into our community.

No one group can be declared responsible for the failure of this bond issue. The university itself, in order to stimulate interest in its functions and community services, held an "open house," but undoubtedly the majority of people who came were friends of the university already and were aware of its civic importance. In addition, university professors and students alike contributed freely of their own time to man the polls on November 8th and distribute information and answer questions. The various mass media of communication were used to disseminate as much information as possible. The fact remains that somewhere along the line there was a breakdown in communication between the university and the public.

Even a superficial examination of the proposed distribution of the $7,000,000 revealed that the standard of medical training and of medical care stood to gain most by this bond issue. Somehow, however, the public missed the fact that they would benefit the most in the long run. The physician, then, who is affected most directly by this improvement in facilities, who is in constant daily contact with the public, and whose opinion commands a great deal of respect can do much to foster the realization that the people are simply doing themselves a good turn in increasing the standards of medical education at the University of Louisville. It is not enough for the Jefferson County Medical Society and the Kentucky State Medical Association to "endorse" the bond issue; more organized action from a group so likely to benefit from such a bond issue is most assuredly called for. After all, the physicians of an area are among its strongest citizens.

It is hard to tell whether the outcome of this vote would have been changed regardless of what we'd done. If nothing else, however, we should have learned the importance of "rallying the home team" before approaching others.

David J. Drutz
Member of Student AMA
U. of L. School of Medicine

KAGP Symposium Draws 46 M.D.'s

The symposium on heart disease, conducted in Louisville November 13 by the Jefferson County Chapter of the KAGP in conjunction with KAGP, was termed highly successful by the chairman, George S. Allen, M.D. A total of 46 physicians registered for the meeting.

Scientific papers were presented by the following Louisville physicians: John L. Wolford, M.D., "Cardiac Failure"; Ralph Denham, M.D., "Valvular Heart Disease"; Carroll H. Robie, M.D., "Hypertensive Heart Disease"; Henry Post, M.D., "Cardiac Arrhythmias;" Henry Clay, M.D., "Pericarditis, Myocarditis and Endocarditis," and Ray Bryant, M.D., "Indications for and Scope of Heart Surgery." A paper, "Myocardial Infarction," by Walter S. Coe, M.D., was read by Doctor Clay in Doctor Coe's absence. Carroll L. Witten, M.D., president of the Jefferson County Chapter, welcomed the physicians.

50 Attend Hopkinsville Seminar

Approximately 50 physicians attended the Hopkinsville Seminar of the Kentucky Academy of General Practice November 10 at the Hopkinsville Golf and Country Club. Preston T. Higgins, M.D., Hopkinsville, served as chairman.

Essayists and their subjects were: Robert Lich, Jr., M.D., Louisville, "Urodiagnosis"; Will W. Ward, Jr., M.D., Louisville, "Practical Application of Pancreatic Function Tests"; James A. Calloway, M.D., Nashville, "Practical Application of Pulmonary Function Tests," and Thomas K. Hepler, M.D., Clarksville, Tenn., "Practical Application of Liver Function Tests." Prof. C. Maxwell Lancaster, Vanderbilt University, was the dinner speaker.

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* *Vacancy to be filled.*

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PG Seminar Well Attended

Fifty-eight physicians and health nurses attended the sixth postgraduate seminar at Madisonville October 12, reports Walter O'Nan, M.D., Henderson, trustee of the Second District. The meeting, held at District One State Tuberculosis Hospital, was sponsored by the KSMA in conjunction with the Kentucky Academy of General Practice.

The scientific program was given by Arthur M. Schoen, M.D., associate professor of medicine at the University of Louisville School of Medicine, who spoke on "Infectious Hepatitis," and Dorothy T. Magallon, M.D., State Department of Health, who discussed "Newer Concepts of Tuberculosis Control." Doctor O'Nan presided.

100 G.P.'s At Psychiatric Seminar

Approximately 100 general practitioners attended a psychiatric seminar at Our Lady of Peace Hospital, Louisville, on October 27, sponsored by the psychiatric staff of the hospital and the Jefferson County Chapter, AAGP. Curtis Prout, M.D., New York psychiatrist, and six Louisville psychiatrists addressed the seminar, said to be the first of its kind ever held in the United States.

M.D.'s Address Hospital Seminar

James T. Gilbert, M.D., Bowling Green, vice-president of the KSMA, and C. C. Howard, M.D., Glasgow, chairman of the Kentucky Hospital Association, were among the speakers at a joint meeting of the Western and Bluegrass Hospital Conferences of the Hospital Association held at Mammoth Cave in early October.

"Better Hospitals for Better Patient Care" was the theme of the two-day session, which was attended by approximately 100 members of the hospital profession.

"Science, Service, and Sentiment of Modern Maternal and Infant Health" is announced as the theme of the Fifth Illinois Congress to be presented by the Illinois Committee on Maternal and Infant Health at the St. Nicholas Hotel in Springfield, Ill., on February 8, 9 and 10, 1961. The program will offer 30 breakfast conferences, eight luncheon conferences, round tables and formal papers.

The Annual Cardiovascular Seminar, sponsored by the Northeast Florida Heart Association, will be held January 26-28 at the Prudential Auditorium in Jacksonville, Fla. Daniel R. Usdin, M.D., president of the association, has announced participating physicians as follows: William Dock, M.D., professor of medicine, New York State University; Lewis Dexter, M.D., assistant professor, Harvard University Medical School; Milton Rosenbaum, M.D., professor and chairman, Department of Psychiatry, Albert Einstein College of Medicine; Richard Ebert, M.D., professor and chairman, Department of Medicine, University of Arkansas School of Medicine.

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In Memoriam

GEORGE R. COE, M.D.
Erlanger
1906 - 1960

George Randolph Coe, M.D., died suddenly of a heart attack at his home Saturday night, November 12. He was 53 years old.

A 1933 graduate of the University of Louisville School of Medicine, Doctor Coe interned at Christ Hospital, Cincinnati. He started practice in Union, Boone County, in 1934 and moved to Erlanger before World War II, in which he served three and a half years as a captain in the U. S. Army. Doctor Coe was a brother of Walter Coe, M.D., Louisville.

M. D. GARRED, M.D.
Ashland
1901-1960

Matthew David Garred, M.D., Ashland, died November 3 after suffering a heart attack while performing an operation at King's Daughters Hospital in Ashland. His brother, E. W. Garred, M.D., Catlettsburg, was assisting in the operation.

Doctor Garred was a 1926 graduate of the University of Louisville School of Medicine.

C. W. CHRISTINE, M.D.
Maysville
1904 - 1960

Chadwick W. Christine, M.D., Maysville, died of leukemia at University Hospital, Columbus, Ohio, on October 28. He was 56 years old.

A 1932 graduate of the University of Louisville School of Medicine, Doctor Christine served as director of the Mason County Health Department from 1938 to 1943 when he entered private practice.

JOHN H. HICKS, M.D.
Louisville
1883-1960

John H. Hicks, M.D., a physician in Louisville for many years, died November 8 at Norton Memorial Infirmary, Louisville.

A native of Grayson County, Doctor Hicks received his M.D. degree from the University of Louisville in 1915.

K. G. SEILER, M.D.
Melber
1916-1960

A heart attack proved fatal to Kingman G. Seiler, M.D., Melber physician, on November 3. He was found dead in his home.

Doctor Seiler was graduated from the University of Louisville School of Medicine in 1943.

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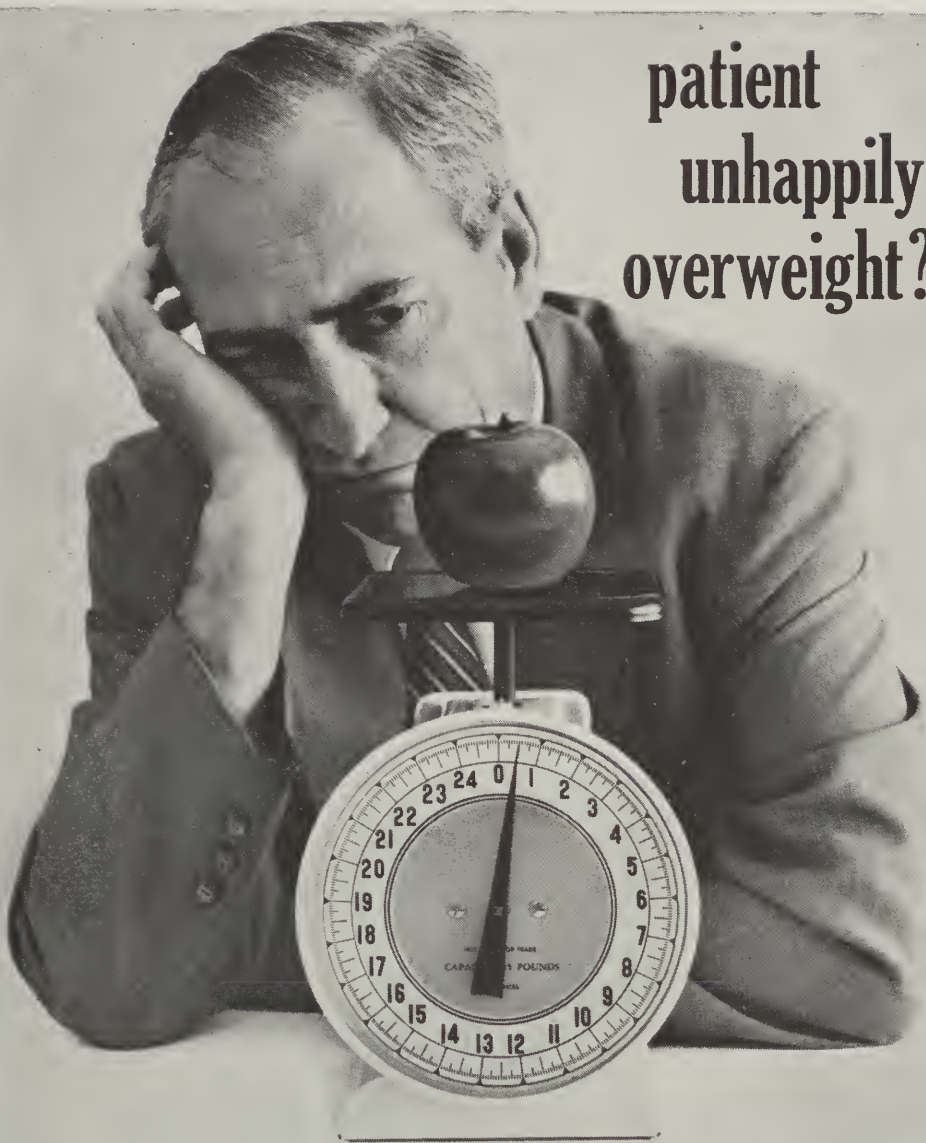
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[1] Douglas, H. S.: West. J. Surg. 59:238 (May) 1951.

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SOME BASIC FACTS ON TAXES

Now Is The Time

YOU will soon be confronted with the task of getting your affairs in order for the filing of your 1960 federal and state tax returns. Some planning between now and the end of the year could result in money saved inasmuch as each $100 sliced off your taxable income saves you a minimum of $20 in taxes.

Examine your cancelled checks and invoices very closely. Have you pulled all checks that could be deductible, either business or personal, for further examination by your accountant? There are probably numerous items in your personal checks that will qualify as deductions if you do not take the standard deduction.

Look back over your calendar for the past year. Have you attended meetings or refresher courses to maintain your skill and to keep you abreast of the latest medical advances? If so, you are entitled to a deduction.

Cash Basis

Most physicians are on the cash basis (cash receipts and disbursements method) of computing income. Under this method, income is reported for the year when it is actually or constructively received, either in the form of cash or its equivalent, or other property. On the other side of the ledger, deductions are taken for the year in which they are actually paid.

Assuming your income is larger this year than normal, you may be looking for extra deductions to keep you out of a larger tax bracket. By being on the cash basis it is possible, for example, to prepay some of your ordinary expenses necessary for your practice by purchasing some of these items prior to the end of the year. This way you could have a deduction that would have been postponed until the following year. In other words, take a complete survey of your upcoming expenses in order that you may intelligently plan ahead tax wise. Of course, this does not apply to capital assets whose costs are recovered over a period of useful life of the asset. Expenses like prepaid rentals and prepaid salaries cannot be wholly deducted in the year paid but must be prorated over the applicable prepaid period.

This same analysis can reap you tax dollars also when you itemize your personal deductions for contributions, taxes, interest, medical costs and casualty losses. Perhaps you have made a pledge to your church which you can fulfill prior to the end of the year—or—make your other charitable contributions before Dec. 31.

Generally, to be deductible, a casualty loss must be sudden and unexpected. Don't neglect the smaller ones, as many people do who think in terms of big catastrophes. Money or property stolen from you is deductible. So is collision damage to your car which is not covered by insurance. A broken water heater, cracked water pipes, termite damage to your house in a short span (2-4 months)—all these are considered as deductible casualty losses.

Entertainment Expense

Physicians are entitled to deductions on their federal tax returns for entertainment costs, provided it can be established to the satisfaction of the U.S. Treasury Department that such expenses are ordinary and necessary business expenses and are clearly related to the production of business income.

First, the amount claimed as a deduction must be proved and its reasonableness determined. If this amount is substantiated, it is then up to the doctor to show that this expense had a direct bearing on his practice and that this entertainment deduction can reasonably be expected to produce additional income by referrals. Hoping or expecting to get business from such expenses isn't valid enough to merit the deduction. Generally, this amount would have to be expended upon other doctors and not patients because b e n e f i t s ordinarily from patients would be small.

Having a bearing on a deduction of this type would be the type of practice the doctor incurring the expenditure is in; how long he has been in practice; what is the size of his practice; number of patients received by referrals; who was entertained and reason why additional income was expected; was any referral or business received as a result of this entertainment and the number of times he entertained. If you can show who was entertained and then from your records show that business was actually received as a result—you should be safe in taking and supporting this deduction.

Now is the time—Get into those records—Look for anything that can legally entitle you to keep extra dollars in your pockets.

William E. Rudd



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atropine sulfate	0.0194 mg.
hyoscine hydrobromide	0.0065 mg.
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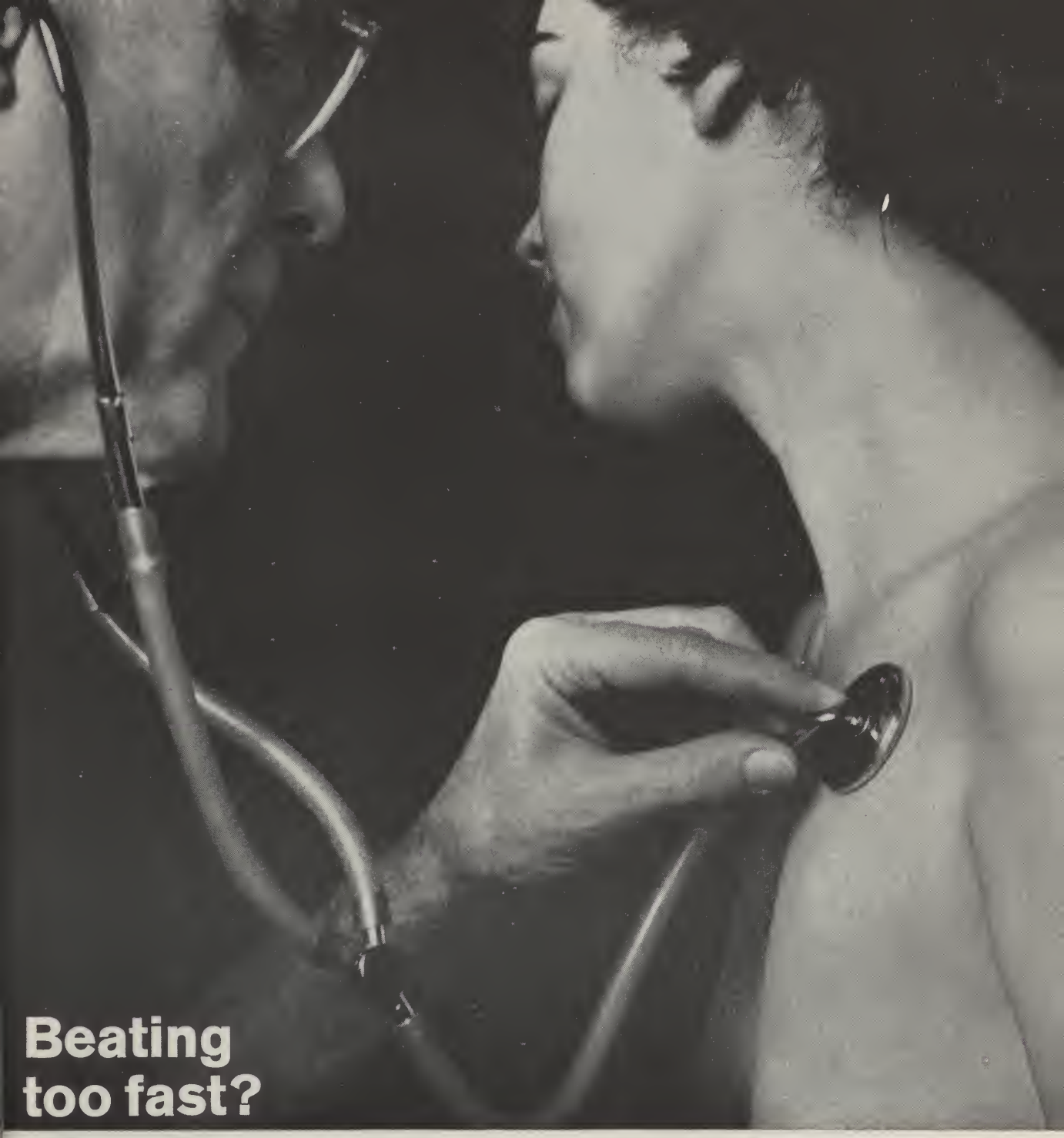
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Christopher's TEXTBOOK OF SURGERY (Seventh Edition): edited by Loyal Davis, M.D.; published by W. B. Saunders Company, Philadelphia and London; 1,551 pages; price, $17.

This established text of general surgery now appears in seventh edition with very little change over the 1956 edition. The chapter on heart surgery has been expanded to include concepts of open heart techniques and new diagnostic techniques. The chapters on wound healing and surgical infections have been largely rewritten to present a wide survey of these basic principles.

The chapters on the abdominal wall and peritoneum and on hernia remain the most lucid and readable in presently available textbooks. The tremendous scope of this book remains a controversial feature for the chapters on Orthopedics, Urology and Gynecology attempt more than can be adequately included in a general surgery text. These survey chapters are somewhat cursory but the bibliographies are extensive.

The single wholly new chapter is on surgical judgment. Although interesting and well written it seems out of place in a student text. The fine illustrations and authoritative discussions continue to make this an excellent textbook for the medical student.

J. Alex Haller, Jr., M.D.

CLINICAL MANAGEMENT OF BEHAVIOR DISORDERS IN CHILDREN: by Harry Bakwin, M.D., and Ruth Morris Bakwin, M.D.; published by W. B. Saunders Company, Philadelphia and London; 597 pages; price, $11.

This is the second edition of this useful text. The authors are pediatricians at Bellevue Hospital in New York and they have an excellent awareness of the psychological side of pediatrics and an informed and healthy approach to its application in actual practice. The book is primarily for pediatricians, general practitioners, students and physicians in general. I suspect that a good many psychiatrists could also profit from the book, although it is not primarily written for psychiatrists.

The text is primarily what its title suggests, namely the clinical management of the emotional difficulties of children by doctors. The book is divided into twelve parts as follows: Growth and Development, Psychologic Care, Care of the Physically Ill and Handicapped Child, Etiologic Factors and Behavior Disorders of Children, Diagnosis and Treatment of Behavior Disorders of Children, Problems Related to Mental Functioning, Developmental Abnormalities, Problems Related to Emotional Development, Problems of Habit and Training, Organic Disturbances with a Large Psychic Component, Antisocial Behavior and Specific Syndromes.

It is an excellent general reference text. The authors comprehensively report on the background history, current theories and objective findings on most of the emotional and behavior problems that are seen in children. The authors use an exhaustive source supply of many authors and quote freely in a well documented fashion.

The authors have used good judgment in their reference sources and are for the most part up to date in their presentations. There is a bibliography at the end of each subtopic and a thorough subject index. The chapter on Parental Attitudes is exceptionally good.

The text is comprehensive but as condensed as any monumental tome could be and still be useful. It is well written and fluently readable. Its over-all content represents an organized combination of material from multiple specialties and multiple disciplines into a whole which presents a reliable text. Pediatrics, Child Psychiatry, Psychology, Adult Psychiatry, Neurology, Sociology and Education are brought together.

Only two minor criticisms seem to be warranted. The first is that the theoretical side of the text is somewhat biased in favor of a biological and organic etiology in some syndromes; e.g., Enuresis, in preference to psychological etiology. The second is that the text is a bit out of date on drug therapy.

What Spock is to parents, this book should be to doctors. It should be a standard reference on the shelf of every physician.

Harvey R. St. Clair, M.D.

COMMUNICABLE AND INFECTIOUS DISEASES (Fourth Edition): Franklin H. Top, M.D., editor; published by C. V. Mosby Company, Inc., St. Louis; 812 pages; price, $20.

This fourth edition of a book on infectious diseases is a welcome one predominantly because of the number of well qualified authors who have written on their own specific interests.

The edition is almost a completely new textbook since many of the chapters have been thoroughly revised and a number of new chapters have been added.

Two chapters, one on chemotherapeutic agents and antibiotics by Dr. Mark Lepper and one on staphylococcal infections by Dr. Ian McLean Smith, are particularly interesting and timely. The remaining chapters are well written and adequately describe our present knowledge of a variety of infectious diseases ranging from the common cold to chickenpox to rickettsial diseases and bacterial infections.

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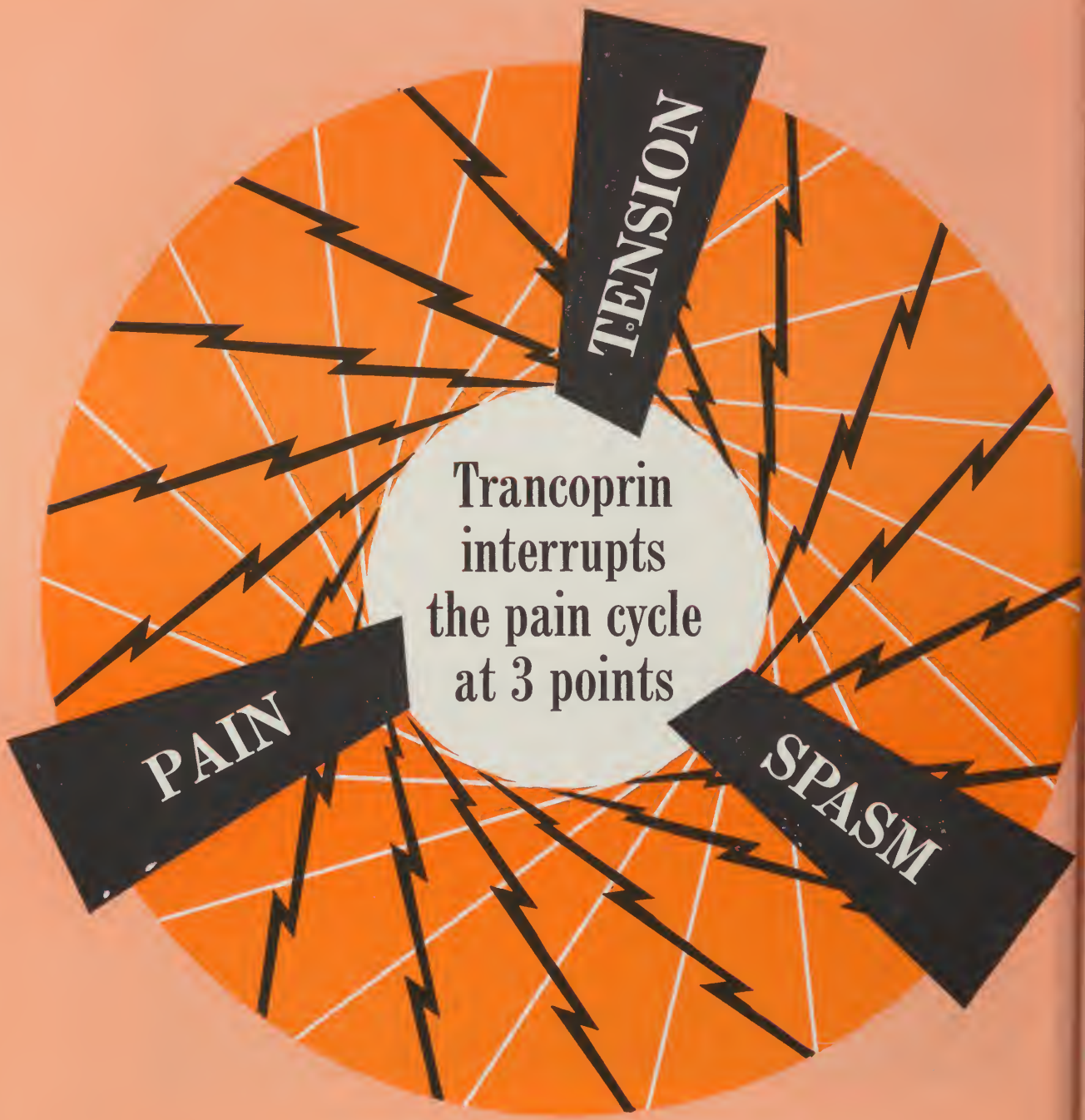
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References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

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MONTGOMERY, ALABAMA
Friday, January 13, 1961
The Whitley Hotel

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Monday, January 16, 1961
The Hotel Leamington

LEMONT, ILLINOIS
Wednesday, January 18, 1961
The White Fence Farm

CINCINNATI, OHIO
Sunday, January 22, 1961
The Netherland Hilton Hotel

NEW DORP, STATEN IS., N. Y.
Wednesday, February 15, 1961
The Tavern-on-the-Green

CHARLESTON, SOUTH CAROLINA
Thursday, February 23, 1961
The Francis-Marion Hotel

ANCHORAGE, ALASKA
Saturday, February 25, 1961
The Westward Hotel

BAKERSFIELD, CALIFORNIA
Friday, March 3, 1961
The Bakersfield Hacienda

WILLIAMSBURG, VIRGINIA
Wednesday, March 8, 1961
The Williamsburg Lodge

ALBUQUERQUE, NEW MEXICO
Saturday, March 11, 1961
The Hilton Hotel

OMAHA, NEBRASKA
Thursday, March 16, 1961
The Sheraton-Fontenelle Hotel

PHOENIX, ARIZONA
Saturday, March 18, 1961
The Westward Ho Hotel

LOUISVILLE, KENTUCKY
Thursday, March 23, 1961
The Sheraton-Seelbach Hotel

BAY SHORE, LONG ISLAND, NEW YORK
Wednesday, April 12, 1961
The LaGrange Inn

BUTTE, MONTANA
Saturday, April 22, 1961
The Finlen Hotel

ITHACA, NEW YORK
Thursday, April 27, 1961
The Statler Club

ERIE, PENNSYLVANIA
Wednesday, May 3, 1961
The Hotel Lawrence

SACRAMENTO, CALIFORNIA
Wednesday, May 10, 1961
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Wednesday, June 7, 1961
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PUBLIC HEALTH PAGE

Behavioral Science In Public Health

RUSSELL E. TEAGUE, M.D., M.P.H. *Commissioner of Health Commonwealth of Kentucky*

AS a logical and fundamental step towards an extended program of service to the citizens of Kentucky, the Department of Health requested —the 1960 Legislative Session and Governor Combs approved—the addition and development of a new division, the Division of Behavioral Sciences, which, it is hoped, will make a major contribution to the development of a comprehensive approach to the public health problems of the State.

Behavioral science is an emerging discipline for public health departments. It has been long recognized that many of the problems confronting public health require a social and behavioral approach as well as medical attention. If Smillie's definition (W. G. Smillie, *Public Health: Its Promise for the Future.* New York: Macmillan Co., 1955, p. 1) of public health as "that responsibility which rests upon the community for the protection of life and the promotion of health of its people" is accepted, then the concepts and skills of behavioral scientists are necessary, for public health must, by definition, be able to investigate and evaluate the reciprocal relationships which exist between health and environment.

Perhaps the medico-behavioral approach can be epitomized by a simple example: it is an individual medical act when a physician treats a patient; it is a public health problem—a social, behavioral, and medical act—when an entire group is in need of innoculation or vaccination.

Public health, by its very nature, requires an interdisciplinary approach to the physical and mental well-being of a population; it must pursue a policy of collaboration and coordination between doctors, nurses, medical and lay organizations, local and legislative bodies; public health must be concerned with the control and prevention of diseases which threaten the community rather than with an illness which affects only one individual in a community. The Kentucky Department of Health, therefore, organizationally and administratively must recognize that a significant area of its program must deal with diseases in a socio-cultural context.

As the American Public Health Association noted at its 87th Annual Meeting in October 1959, ". . . Knowledge of human behavior has become as significant as knowledge of bacteriology and epidemiology in approaching many community health problems" (*American Journal of Public Health,* Vol. 49, No. 7, p. 949).

Although the Kentucky Department of Health's Division of Behavioral Sciences brings a new focus to public health problems, it is essentially a conjoint part of a program rather than an isolated or separate unit. In order to explore relationships between behavioral and environmental factors and public health, the various divisions and bureaus of the Department will, in collaboration with local health teams, develop an interdisciplinary approach to the problem of community health.

The Department of Health will initiate studies in which a multidisciplinary approach (behavioral scientists — anthropologists, sociologists, and social psychologists, in association with medical practitioners and paramedical personnel) will investigate the relation between social factors and illness, and the factors which contribute to the prevention, prophylaxis, care, therapy, and reactivation of patients.

In addition, it is hoped that independent behavioral science studies can be initiated which examine the administrative, organizational, and social structure of institutions; the relation between the institutional structure and the application of new methods and measures for the medical care and treatment of a population grouping, and the application of such organization procedures to public health. There are an infinite number of other areas in which a behavioral science approach could provide valuable information —from the dissemination and acceptance of health educational material to the technical assistance which behavioral scientists could give to the staff in the development of research projects.

The Department of Health, through its Behavioral Sciences and Statistical Services Divisions, is committed to an applied research program in three major areas; these operationally defined study areas are

(Continued on Page 1538)

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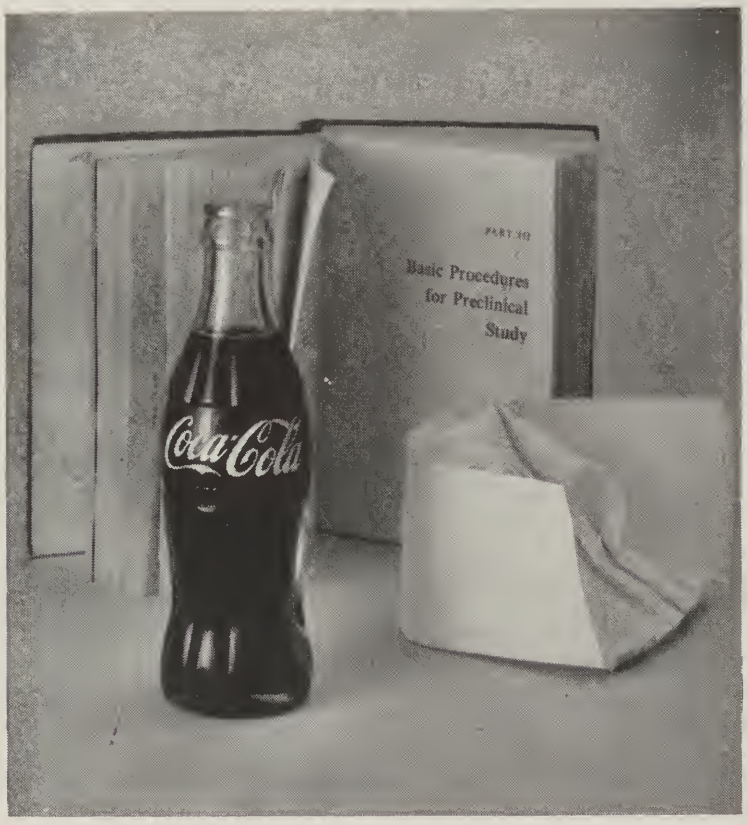


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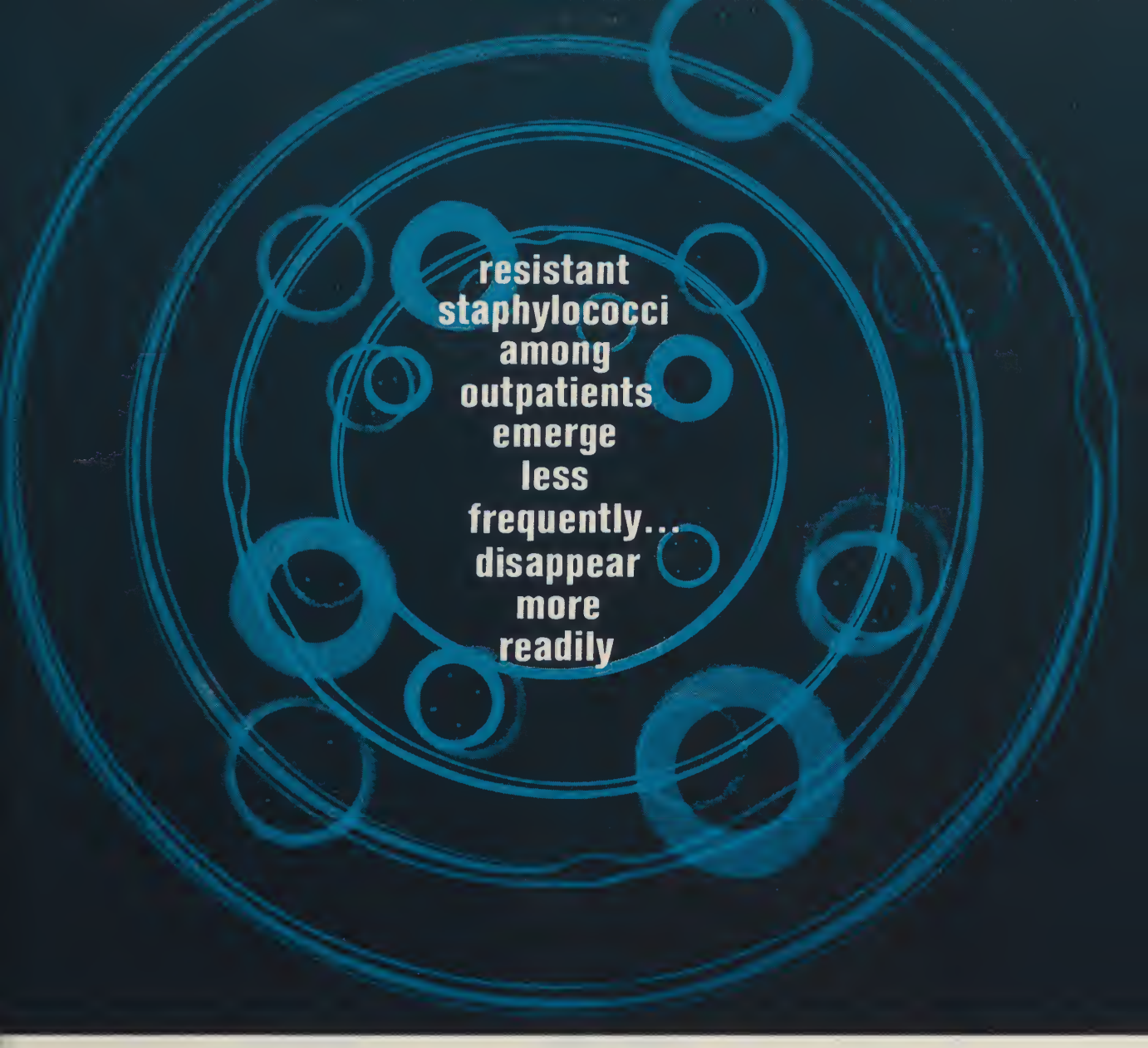
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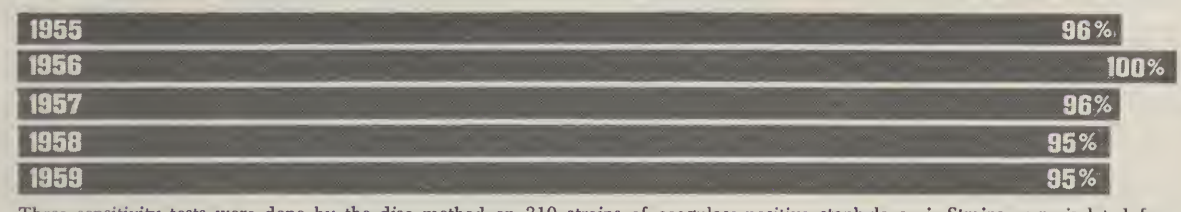
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REFERENCES:

1. Scherbel, A. L.; Schuchter, S. L., and Harrison, J. W.: Cleveland Clin. Quart. 24:98, April, 1957.
2. Waine, Hans: Arthritis, rheumatoid, in Conn, H. F.: Current Therapy 1959, Philadelphia, W. B. Saunders Co., 1959, p. 565.

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1960 CONSTITUTION AND BYLAWS OF THE KENTUCKY STATE MEDICAL ASSOCIATION

Revised September 21, 1960

CONSTITUTION

Article I. Name of the Association
Article II. Purpose of the Association
Article III. Component Societies
Article IV. Composition and Meetings of the Association
Article V. Officers
Article VI. House of Delegates
Article VII. Districts, Sections and District Societies
Article VIII. Board of Trustees
Article IX. Funds and Expenses
Article X. Referendum
Article XI. The Seal
Article XII. Amendments
Article XIII. Definitions

Article I. Name of Association

The name and title of this organization shall be the Kentucky State Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee from each District that may be established, and such other officers as may be provided for in the bylaws.

Section 2. The duties and terms of office of all officers of the Association shall be as prescribed in the bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component societies in such manner as may be provided in the bylaws. Officers of the Association, Delegates and Alternate Delegates to the American Medical Association, and the five immediate Past Presidents shall be ex officio members of the House of Delegates and entitled to vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable. Provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select, including but not limited to an equal per capita assessment by class of membership, upon each component county society. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active

membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I. Membership
Chapter II. Annual and Special Meetings of the Association
Chapter III. The House of Delegates
Chapter IV. Election of Officers
Chapter V. Duties of Officers
Chapter VI. Board of Trustees
Chapter VII. Standing Committees and Councils
Chapter VIII. Assessments and Expenditures
Chapter IX. Rules of Conduct
Chapter X. Rules of Order
Chapter XI. County Societies
Chapter XII. Amendments

CHAPTER I. MEMBERSHIP

Section 1. A member of this Association must also be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KSMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship.

Section 2. Membership in the Association shall be divided into seven classes, to-wit: Active, Emeritus, Associate, Inactive, Student, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component county medical societies. To be eligible for active membership in any component county society, the applicant must be a doctor of medicine of good moral, ethical, and professional standing, who is licensed to practice medicine in Kentucky.

(b) Emeritus Members. Component secieties may elect as a member-emeritus any doctor of medicine who is 70 years of age or who has retired from active practice and who has previously maintained active membership in good standing in his own society for twenty years or more. Emeritus members shall have the right to vote but shall not pay dues, hold office or be entitled to the benefits of Chapter VI, Section 9 of these Bylaws. They shall receive the Journal and other publications of the Association.

(c) Associate Members. The associate membership of the Association shall consist of the associate members of the various component county medical societies. To be eligible for associate membership in any component county society, the applicant must be ineligible for active membership and qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

(2) Interns, residents or teaching fellows who are doctors of medicine and who have complied with all pertinent regulations of the State Board of Health.

Associate members shall not have the right to vote nor to hold office, but shall receive the Journal and other publications of the Association.

(d) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive the Journal and other publications of the Association.

(e) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. Student members shall receive the Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year.

(f) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(g) Special Members. Component societies may invite dentists, pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded

the privilege of attending and participating in the scientific meetings of the society. Provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 4. Except as provided in Chapter VI, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association, shall be entitled to any of the rights or benefits of membership in this Association.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or one of the vice presidents. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of delegates representing fifty or more component societies. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active members of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 6. A majority of the registered delegates shall constitute a quorum and all of the meetings of the House shall be open to members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 7. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary following its introduction. If the author be an individual member, it shall be signed by him. If the author be a group of members, it shall be signed by the authorized spokesman for that group. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 8. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 9. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 10. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

Section 11. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 12. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 13. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 14. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 15. The state shall be divided into the following districts:

No. 1.—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Sipmson, and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8—Boone, Campbell, and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10—Fayette, Jessamine, and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 16. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 17. Except as provided in Chapter VI, Section 5, it shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 18. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. The President-Elect and the Vice Presidents shall be elected for a term of one year. The Speaker and Vice Speaker of the House of Delegates shall be elected for a term of three years. The Secretary and Treasurer shall be elected for terms of five years. The Trustees shall be elected for terms of three years and shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice President, Speaker or Vice Speaker of the House of Delegates, or Trustees, who has not been an active member of the Association for at least five years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as chairman at an organization meeting held during the County Society Officers' Conference, or at some other appropriate place designated by the Board of Trustees at least four months before the Annual Meeting. The Committee, in addition to such other meetings as it may choose to hold, shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the Committee shall have a hearing. Before noon of the following day, the Committee shall post a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nominations for each office to be filled, and shall formally present said nominations to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussions or comment.

Section 3. The election of officers shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect. Provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of the Association shall be ineligible for any office for two years.

Section 6. The Delegates representing the counties in each District shall form the Nominating Committee for the purpose of nominating a Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting, for the purpose of discussing the nomination for the Trustee to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President, in an amount not to exceed the total amount appropriated for that purpose in the annual budget.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice Presidents shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice President from the district from which the President was elected shall succeed to the office of the President.

Section 4. The President-Elect and the Vice Presidents, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties, in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses of the President.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a

non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary shall advise the Executive Secretary in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and in the event of the death, resignation or removal of the Executive Secretary, shall assume the duties of that office until the vacancy is filled.

Section 8. The Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or the Executive Secretary and shall be countersigned by the Treasurer of the Association. Under unusual circumstances, when one or more of the above-named officials are not readily available, the President or the Chairman of the Board of Trustees is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Board of Trustees. The Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the three Vice Presidents, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the President-Elect, the Secretary, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, 4, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the existing component societies and their members. He shall likewise hold at least one district meeting each year in order to afford a forum for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Treasurer upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Meeting of the Association.

Section 4. Collectively the Board shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or a component society upon which appeal is taken from the decision of an individual Trustee or District Grievance Committee. In hearing appeals, the Board may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, efforts toward conciliation and compromise shall precede all such hearings. Its decision in all such cases shall be final.

Section 5. The Board shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press. Such communications shall be signed by the President of the Association and the Chairman of the Board.

Section 6. The Journal of the Kentucky State Medical Association shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the Journal shall be elected by the Board. All money received by the Journal or by any member of its staff on its behalf, shall be paid to the Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 7. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 8. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the President may call a meeting of the delegates of record from the counties of that district for the purpose of submitting one or more nominees as candidates to fill the office until the Trustee's disability is removed or until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Board, which may elect an acting Trustee from them.

Section 9. A Medico-Legal Administrator shall be appointed by the Board to serve for a term of three years. The Executive Committee of the Board shall act in an advisory capacity to the Administrator. The Association, through the Administrator shall, upon the request of any member in good standing who is

a defendant in a professional liability suit, provide such member with the consultative service of competent legal counsel selected by the Administrator acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 10. The Board shall employ an Executive Secretary whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Secretary shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Treasurer. He shall within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a card index register of all practitioners in the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor of the Journal of the Kentucky State Medical Association under supervision of the Board and in a similar capacity to the extent that other publications are authorized by the House of Delegates.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. STANDING COMMITTEES AND COUNCILS

Section 1. The Board of Trustees shall, upon nomination of its Executive Committee, appoint and designate the chairmen of five standing committees composed of not less than five nor more than seven members, as follows:

(a) A Committee to Study the Constitution and Bylaws
(b) A Committee on Third-Party Medicine
(c) A Committee on Professional Relations
(d) A Committee on Arrangements for the County Society Officers' Conference
(e) An Advisory Committee to the Editor of the Journal

Section 2. The Board of Trustees shall, in the same manner, (except as hereinafter provided) appoint and designate the chairmen of six Councils, composed of not less than five nor more than seven members, as follows:

(a) A Council on Scientific Assembly.
(b) A Council on Medical Education and Hospitals.
(c) A Council on Legislative Activities.
(d) A Council on Medical Services.
(e) A Council on Communications and Public Service.
(f) A Council on Allied Professions and Related Groups.

Section 3. The Executive Committee shall serve as the nominating committee for all Standing Committee and Council appointments, but the Trustees may make additional nominations from the floor. When the Executive Committee sits as such nominating committee, the President shall serve as Chairman.

Section 4. Except as otherwise provided herein, members of Standing Committees and Councils shall be appointed for terms of not less than one year and of not more than three years, and until their successors are appointed. Each committee and council shall meet and organize as soon after its appointment as possible, and shall meet again near the close of the associational year, for the purpose of formulating its annual report. It may meet at such other times as may be necessary or desirable. The Headquarters Office shall be the headquarters for all Committees and Councils, unless otherwise specifically ordered by the Board of Trustees or its Executive Committee.

Five-member Committees and Councils shall have a quorum of three, and seven-member Committees and Councils shall have a quorum of four members present before any business other than the fixing of the time and place of the next meeting, may be transacted.

Each Standing Committee and Council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted, without alteration or amendment, to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. Committees and Councils may submit supplemental reports if such reports are in the hands of the Secretary at least 48 hours in advance of the first meeting of the Regular Session of the House of Delegates.

Section 5. The President, Secretary, and Executive Secretary shall be ex officio members of all Committees and Councils, without power to vote except as otherwise specified herein.

Section 6. The Board of Trustees shall have power to establish such other committees as may, from time to time, appear to it to be advisable, and to prescribe their composition, the method of their appointment, and their duties. Such committees shall serve at the pleasure of the Board.

In addition, the Board of Trustees shall have power to appoint a representative from this Association to the Conference of Presidents and such other organizations as it shall determine.

Section 7. The Committee to Study the Constitution and Bylaws shall make a continuing study of the Constitution and Bylaws and shall annually recommend such revisions of either or both of these documents as changing times and conditions indicate.

Section 8. The Committee on Third Party Medicine shall make a continuing study of Third Party Medicine, and shall maintain liaison with all medical care plans which employ physicians on a salaried basis in this state. It shall mediate disputes between members and such plans, and shall continually strive to persuade such plans to shape their relations with their employed physicians and with the public, in conformity to the views of this Association.

Section 9. The Professional Relations Committee shall supervise and coordinate the work of the various District Grievance Committees hereinafter created. The Trustee of each District is hereby designated the Chairman of his District Grievance Committee. The Professional Relations Committee shall designate two (2) additional Trustees from Districts adjoining that of the Chairman, and the three Trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual Trustees, shall be referred to the District Grievance Committee for the District in which the respondent physician or county society resides. If requested to do so, the District Grievance Committee shall hold hearings and hear evidence and render a decision based upon the evidence thus presented. Any party aggrieved by the decision of the District Grievance Committee, shall have the right to appeal to the Board of Trustees in the manner provided by Section 4 of Chapter VI of these Bylaws.

All grievances, whether handled by individual Trustees or by District Grievance Committees, shall be reported to the Professional Relations Committee, which shall include in its report to the Board of Trustees, a statistical resume of the number of cases handled and the disposition thereof. In addition, the Professional Relations Committee shall make recommendations to the Board of Trustees with respect to any course of action which the Committee determines to be desirable, in the light of its experience during the year covered by its report.

Section 10. The Committee on Arrangements for the County Society Officers' Conference shall have the responsibility of preparing the program for the County Society Officers' Conference, and presenting it to the Board of Trustees or its Executive Committee for approval. Upon approval of the program thus presented, the Committee shall have the further responsibility of approving all arrangements for the Conference.

Section 11. The Advisory Committee to the Editor of the Journal shall provide support to the Editor and be available to him for consultation with respect to any matter concerning the Journal, on which he desires the Committee's advice and assistance. All papers of doubtful suitability for publication shall be referred by the Editor to the Advisory Committee, and its approval shall be required prior to the publication of any matter which is recognized to be of a controversial nature.

Section 12. The Council on Scientific Assembly shall consist of seven (7) members. The President, the President-Elect, and the chairmen of the Committees on Scientific and Technical Exhibits shall, by virtue of their respective offices, be voting members of the Council, with the President serving as Chairman and the President-Elect as Vice-Chairman. The remaining three members shall serve for terms of three (3) years each, with the term of one member expiring each year. The Council shall supervise and direct the planning, development and presentation of the scientific programs of the Annual Meeting each year. In addition, it shall be responsible for scientific and technical exhibits and all activities incident to the Annual Meeting, including golf and other forms of recreation and entertainment. These will include the duties heretofore imposed upon the Awards Committee to nominate the recipients of the Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award.

Thirty (30) days previous to each Annual Meeting, the Council shall prepare and issue a program announcing the order in which papers, discussions, and other business shall be presented, which program shall be adhered to as nearly as practicable. No county society, as such, shall serve as host society to the Annual Meeting.

Section 13. The Council on Medical Education and Hospitals shall direct and supervise the activities of the Association in the field of medical education, and shall maintain active liaison with the Kentucky Hospital Association. It shall seek to elevate the standards of postgraduate medical education in Kentucky, establishing and maintaining liaison with Kentucky's two medical schools and the Committee for the American Medical Education Foundation, and concerning itself with problems relating to medical and hospital care, general practice, and such other matters in this general field as may be referred to it by the Board.

Section 14. The Council on Legislative Activities shall direct and supervise the work of the Association as it pertains to state and national legislation, and shall formulate and submit a legislative program to the Board of Trustees for its consideration. The Council shall seek the enactment of the Association's legislative program into law, and shall resist the enactment of bills which the Board finds to be not in the best interests of the public or the profession. It shall maintain liaison with officials of state and national governments and shall work closely with the various county societies in carrying out the legislative program at both state and national levels.

Section 15. The Council on Medical Services shall supervise and direct the activities of the Association in the field of socio-economic development. It shall be charged with the promotion of voluntary health insurance programs in general and shall maintain active liaison with Kentucky Physicians Mutual, Inc., and Blue Cross plans. It shall advise on medical service contracts with the state and federal governments and shall serve as a clearing house on all fee schedules and other questions affecting the economics of medicine. It shall concern itself with the problem of providing adequate medical care for the aged, and shall maintain careful scrutiny of all state or national programs which purport to deal with this problem.

Section 16. The Council on Communications and Public Service shall supervise and direct all associational activity in the fields of public relations and service, including, but not limited to, rural health, schools, public health, emergency medical services and diabetes.

Section 17. The Council on Allied Professions and Related Groups shall concern itself with the development and promotion of improved health standards and shall establish and maintain liaison with the dental, nursing and pharmacy professions in this state. It shall supervise and direct the Association's activities in the fields of infant and maternal mortality, physical medicine and rehabilitation, industrial medicine, tuberculosis, blood banks and other related subjects, and shall interest itself in the work of voluntary health associations.

CHAPTER VIII. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Members, $50, except Active Members who devote all of their time to teaching or research and have no private practice, $25; (2) Emeritus Members, no dues; (3) Associate Members, $8; (4) Inactive Members, $8; (5) Student Members, $1; (6) Honorary Members, no dues; (7) Special Members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each component society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association as of the first day of January in each year.

Section 2. Any component society which fails to

ANNOUNCING—
SPECIFICALLY FOR
INFECTIONS DUE TO
"RESISTANT" STAPHYLOCOCCI

AN ENTIRELY NEW SYNTHETIC
"STAPH-CIDAL" PENICILLIN

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

UNIQUE—BECAUSE IT
RETAINS ANTIBACTERIAL
ACTIVITY IN THE PRESENCE OF
STAPHYLOCOCCAL PENICILLINASE
WHICH INACTIVATES
OTHER PENICILLINS

Bristol™

NEW SYNTHETIC PENICILLIN FOR "RESISTANT" STAPH

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OFFICIAL PACKAGE CIRCULAR
November, 1960

STAPHCILLIN™

(sodium dimethoxyphenyl penicillin)
For Injection

DESCRIPTION

STAPHCILLIN is a unique new synthetic parenteral penicillin produced by Bristol Laboratories for the specific treatment of staphylococcal infections due to resistant organisms. Its uniqueness resides in its property of resisting inactivation by staphylococcal penicillinase. It is active against strains of staphylococci which are resistant to other penicillins.

Each dry filled vial contains: 1 Gm. STAPHCILLIN (sodium dimethoxyphenyl penicillin), equivalent to 900 mg. dimethoxyphenyl penicillin activity.

INDICATIONS

STAPHCILLIN is recommended as specific therapy only in infections due to strains of staphylococci resistant to other penicillins, e.g.:

Skin and soft tissue infections: cellulitis, wound infections, carbuncles, pyoderma, furunculosis, lymphangitis and lymphadenitis.

Respiratory infections: staphylococcal lobar or bronchopneumonia, and lung abscesses combined with indicated surgical treatment.

Other infections: staphylococcal septicemia, bacteremia, acute or subacute endocarditis, acute osteomyelitis and enterocolitis.

Infections due to penicillin-sensitive staphylococci, streptococci, pneumococci and gonococci should be treated with Syncillin® or parenteral penicillin G rather than STAPHCILLIN. Treponemal infections should be treated with parenteral penicillin G.

DOSAGE AND ADMINISTRATION

STAPHCILLIN is well tolerated when given by deep intragluteal or intravenous injection.

As is the case with other antibiotics, the duration of therapy should be determined by the clinical and bacteriological response of the patient. Therapy should be continued for at least 48 hours after the patient has become afebrile, asymptomatic and cultures are negative. The usual duration has been 5-7 days.

Intramuscular route: The usual adult dose is 1 Gm. every 4 or 6 hours. Infants' and children's dosage is 25 mg. per Kg. (approximately 12 mg. per pound) every 6 hours.

Intravenous route: 1 Gm. every 6 hours using 50 ml. of sterile saline solution at the rate of 10 ml. per minute.

**Warning:* Solutions of STAPHCILLIN and kanamycin should not be mixed, as they rapidly inactivate each other. Data on the results of mixing STAPHCILLIN with other antibiotics are being accumulated.

DIRECTIONS FOR RECONSTITUTION

Add 1.5 ml. sterile distilled water or normal saline to a 1 Gm. vial and shake vigorously. Withdraw the clear, reconstituted solution (2.0 ml.) into a syringe and inject. The reconstituted solution contains 500 mg. of STAPHCILLIN per ml. Reconstituted solutions are stable for 24 hours under refrigeration.

For intravenous use, dilute the reconstituted dose in 50 ml. of sterile saline and inject at the rate of 10 ml. per minute.

*This statement supersedes that in the Official Package Circulars dated September and/or October, 1960.

(continued)

MICROBIOLOGICAL AND PHARMACOLOGICAL PROPERTIES

In vitro studies show that STAPHCILLIN is a bactericidal penicillin with activity against staphylococci resistant to penicillin G. Strains of staphylococci so far tested have been sensitive to STAPHCILLIN *in vitro* at concentrations of 1-6 mcg. per ml. These levels are readily attained in the blood and tissues by administration of STAPHCILLIN at the recommended dosage. This unique attribute is probably due to the fact that STAPHCILLIN is stable in the presence of staphylococcal penicillinase. STAPHCILLIN also resists degradation by *B. cereus* penicillinase. The antomicrobial spectrum of STAPHCILLIN with regard to other microorganisms is qualitatively similar to that of penicillin G; but considerably higher concentrations of STAPHCILLIN are required for bactericidal activity than is the case with penicillin G.

STAPHCILLIN is rapidly absorbed after intramuscular injection. Peak blood levels (6-10 mcg./ml. on the average after a 1.0 Gm. dose) are attained within 1 hour; and then progressively decline to less than 1 mcg. over a 4 to 6 hour period. It is poorly absorbed from the gastrointestinal tract. STAPHCILLIN is rapidly excreted by the kidney.

As shown by animal studies, STAPHCILLIN is readily distributed in body tissues after intramuscular injection. Of the tissues studied, highest concentrations are reached in the kidney, liver, heart and lung in that order; the spleen and muscles show lower concentrations of the antibiotic. STAPHCILLIN diffuses into human pleural and prostatic fluids, but its diffusion into the spinal fluid has not yet been completely studied. However, one patient with meningitis showed a significant concentration in his spinal fluid while on STAPHCILLIN therapy.

Toxicity studies with STAPHCILLIN and penicillin G in animals show that they have approximately the same low order of toxicity.

Certain staphylococci can be made resistant to STAPHCILLIN in the laboratory, but this resistance is not related to their penicillinase production. During the clinical trials, no STAPHCILLIN-resistant strains of staphylococci were observed or developed; the possibility of the emergence of such strains in the clinical setting awaits further observation.

PRECAUTIONS

During the clinical trials, several mild skin reactions, e.g., itching, papular eruption and erythema were observed both during and after discontinuance of STAPHCILLIN therapy. Patients with histories of hay fever, asthma, urticaria and previous sensitivity to penicillin are more likely to react adversely to the penicillins. It is important that the possibility of penicillin anaphylaxis be kept in mind. Epinephrine and the usual adjuvants (antihistamines, corticosteroids) should be available for emergency treatment. Because of the resistance of STAPHCILLIN to destruction by penicillinase, parenteral *B. cereus* penicillinase may not be effective for the treatment of allergic reactions. Information with regard to cross-allergenicity between penicillin G, penicillin V, phenethicillin (Syncillin) and STAPHCILLIN is not available at present. If superinfection due to Gram-negative organisms or fungi occurs during STAPHCILLIN therapy, appropriate measures should be taken.

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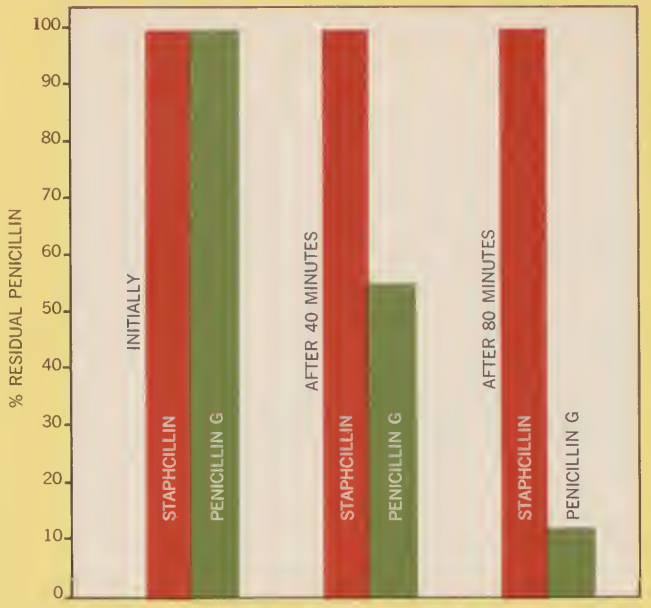
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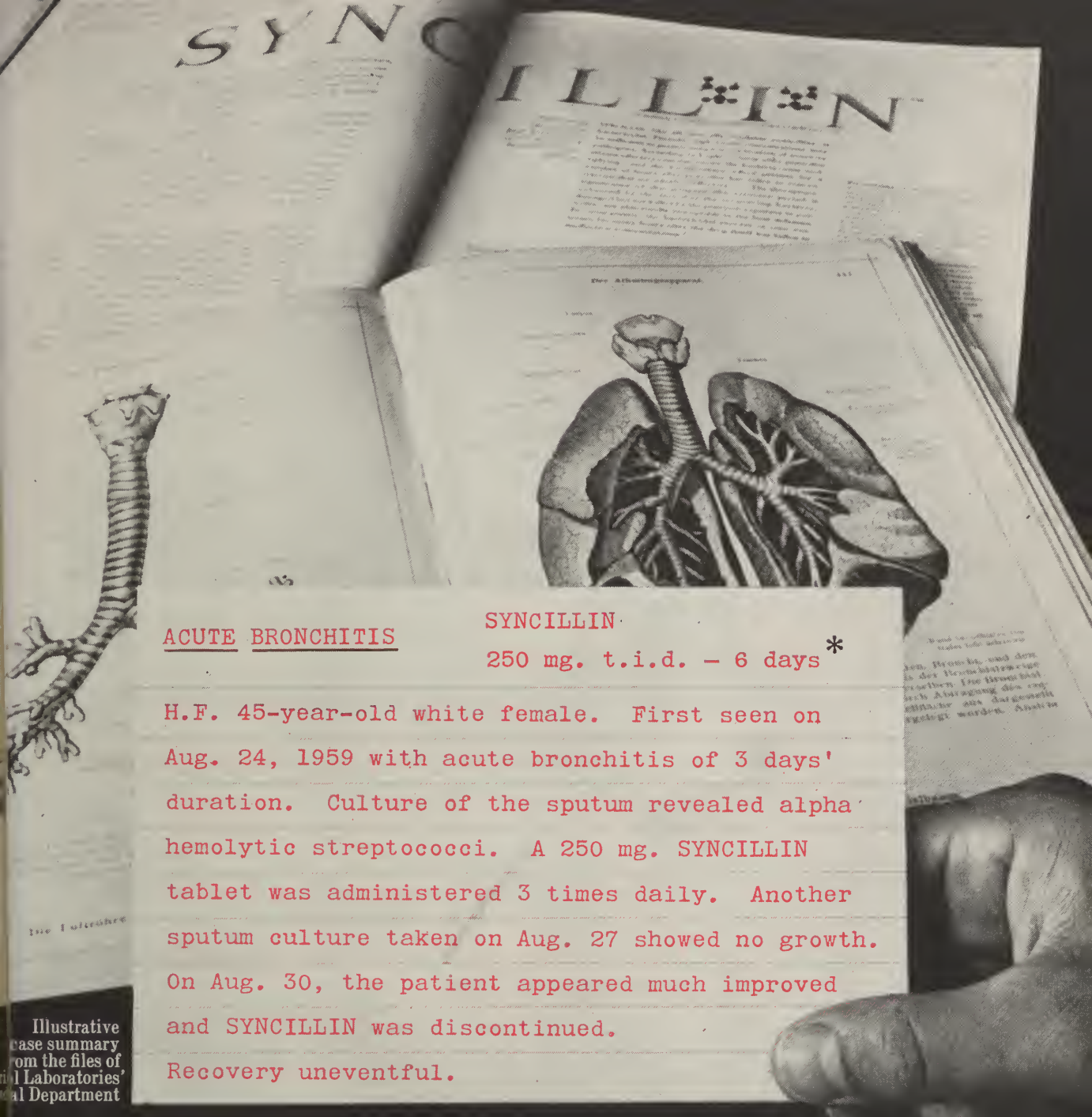
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PROFESSIONAL INFORMATION SERVICE — The attached Official Package Circular provides complete information on the indications, dosage, and precautions for the use of STAPHCILLIN. If you desire additional information concerning clinical experiences with STAPHCILLIN, the Medical Department of Bristol Laboratories is at your service. You may direct your inquiries via collect telephone call to New York, PLaza 7-7061, or by mail to Medical Department, Bristol Laboratories, 630 Fifth Ave., N. Y. 20, N. Y.

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pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective.

CHAPTER IX. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER X. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

CHAPTER XI. COUNTY SOCIETIES

Section 1. Except as provided in Section 4 of this Chapter, all county medical societies in this state which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary. The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 4. Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one statewide society of worthy Negro physicians who are not members of any component society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky State Medical Association.

Section 5. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Section 6. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky State Medical Association, and shall be classified in accordance with Chapter I, Section 2, of these Bylaws. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 7 and/or 9 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 7. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides. (Disciplinary procedures are governed by Section 4, Chapter VI of these Bylaws.)

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 9. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 10. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section 12. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session. Provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 members in good standing, plus one delegate for one or more members in excess of multiples of 25. Provided, however that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KSMA Headquarters Office with a certified list of its delegates each year.

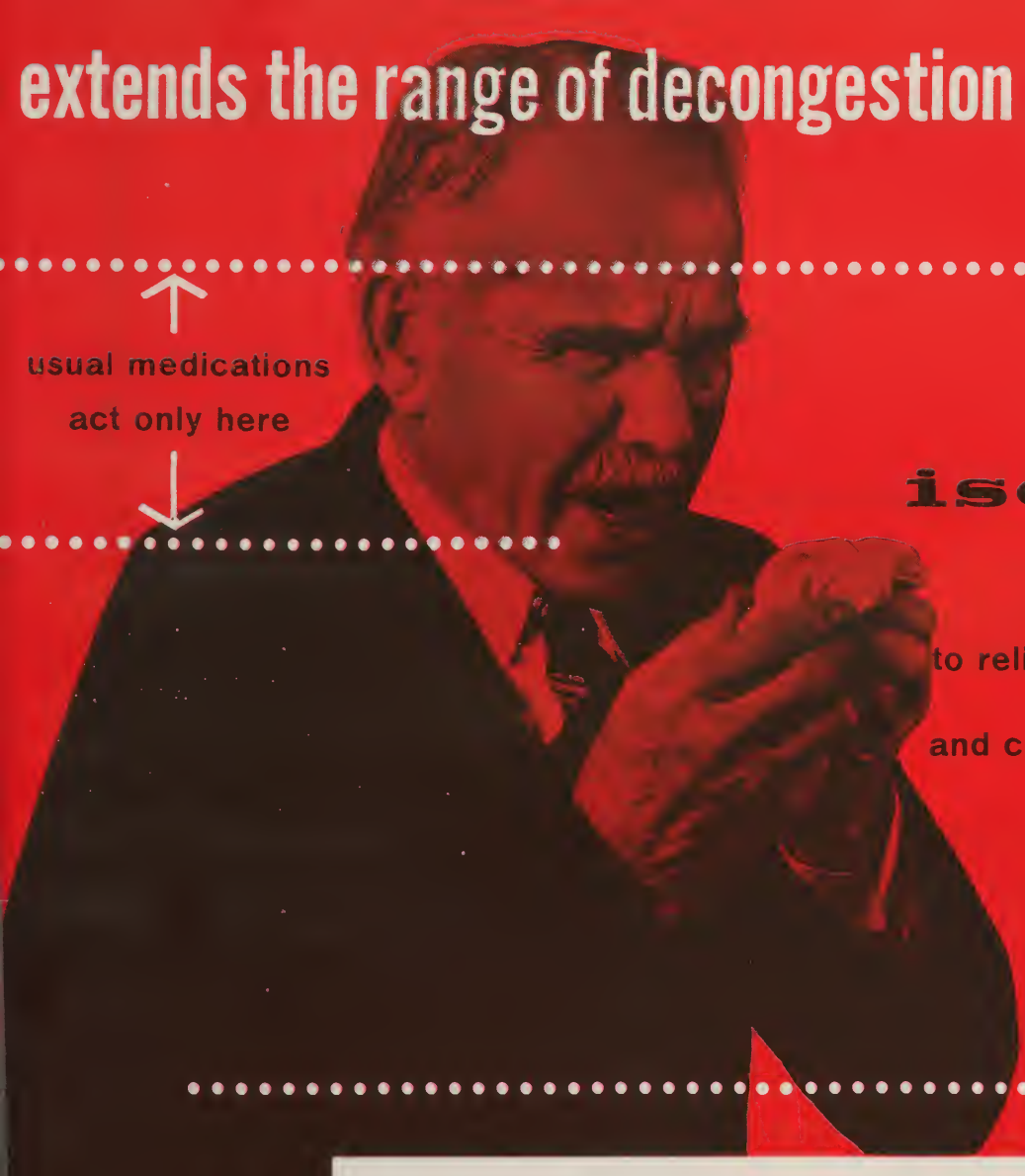
Section 13. The secretary of each component society shall keep a roster of its members and a list of non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary of the Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each component society shall report to the Journal of the Kentucky State Medical Association full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

CHAPTER XII. AMENDMENTS

These Bylaws may be amended at any session of the House of Delegates by a two-thirds vote of all the delegates present at that session, after the amendment has laid on the table for one day.

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1. Aviado, D. M. et al: J. Pharmacol. & Exper. Therap. 122: 406-417 (Mar.) 1958. 2. Laboratory Report: Research Div., Chas. C. Haskell & Co., 1959.

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Friedman, A. P., and Merritt, H. H.: J.A.M.A. *163*:1111 (Mar. 30) 1957.

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SANDOZ

Heinz Lord, M.D., a practicing surgeon of Barnesville, Ohio, has been elected secretary general of the World Medical Association, with headquarters in New York City. He will take office on January 1, 1961, succeeding Louis H. Bauer, M.D., of New York City, who will become consultant to the association. Doctor Lord, a Peruvian citizen by birth, received his preliminary education in Germany.

The Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va., has scheduled its 34th annual Spring Congress in Ophthalmology and Otolaryngology and Allied Specialties, April 3 - 8, 1961. There will be 20 guest speakers and 50 lectures, according to E. G. Gill, M.D.



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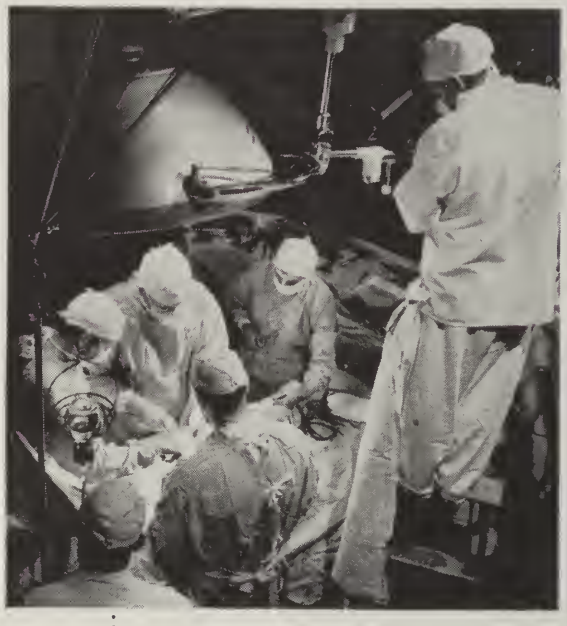
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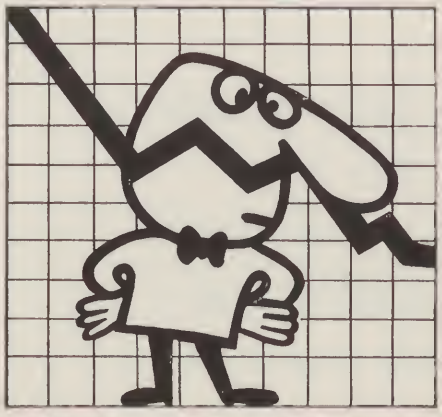
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References: 1. Pitts, R. F., Am. J. Med., 24:745, 1958. 2. Ford, R. V., Cur. Therap. Res., 2:51, 1960.

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based on the recommendations made by the Association of State and Territorial Health Officers in November 1955:

(1) Research that can be expected to result in improved health, medical care, or rehabilitation services;

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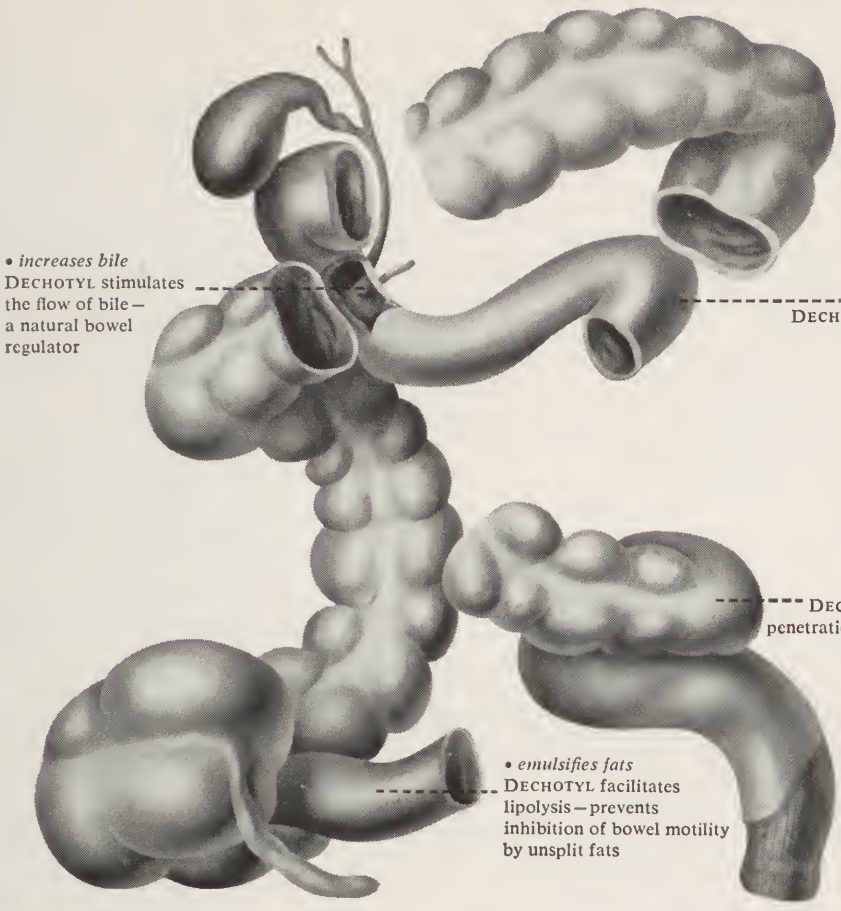
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